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Talking about Life in a Serious Way

Existential-phenomenological Therapeutic
Practice in Primary Care

Doctorate in Counselling Psychology and Psychotherapy by
Professional Studies
(DCPsych)

The University of Middlesex & The New School of Psychotherapy and Counselling

London, July 2016

Supervised by Dr Patricia Bonnici and Dr Joël Vos

To the participants of this project who generously gave their time and reflections

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ABSTRACT

Theoretical literature suggests that the counselling psychology core modality of existential therapy provides a good fit with the NHS primary care context, despite a lack of research and official recognition.

The outlined research qualitatively enquires into the experience of practitioners delivering existential-phenomenological practice within primary care. The focus lies on developing a theory of how these practitioners negotiate their professional practice.

Nine practitioners of varying degrees of experience were interviewed and a theory was iteratively constructed, employing a constructionist Grounded Theory methodology. The resulting theory comprises of four major categories: 'The Medicalness of Primary care', 'Existential-phenomenological Practice in Primary Care', 'Negotiating Practice in Primary Care' and 'The Impact of Professional Experience'. These were verified through a member check with a subsample of seven participants.

Existential-phenomenological practice in primary care is conceptualised as a multi-faceted practice, integrated by a flexible existential-phenomenological 'attitude'. Working to the demands of the medical model of primary care present a departure from more traditional existential therapy and practitioners are often ambivalent about this. Yet, the grounded theory suggests that practitioners are able to maintain their existential-phenomenological identity, and that they perceive their work to be both possible and valuable.

The present theory outlines some of the demands that primary care makes on existential-phenomenological practice, but also the practice-strategies employed to negotiate these. These include limitations in time, goal-setting, psychometric tests, diagnostic labels and differing levels of practitioner experience. Especially for novice practitioners, but also training institutions this outline might serve to tackle the lack of practice guidelines in the field of existential-phenomenological practice in primary care.

Overall, the findings contribute to a dialogue between the community of existential-phenomenological practitioners and the medical model. Further, they support future research that might argue for an inclusion of existential-phenomenological practice into primary care offerings.

Keywords: Existential, phenomenological, primary care, counselling psychology, psychotherapy, negotiating practice, grounded theory, brief, time-limited therapy

STATEMENT OF AUTHORSHIP

This dissertation is written by Christian Koebbel and has research ethics approval from the New School of Psychotherapy and Counselling and Middlesex University.

It is submitted in partial fulfilment of the requirements of the New School of Psychotherapy and Counselling and the School of Science and Technology, Middlesex University for the Degree of Doctorate in Counselling Psychology and Psychotherapy by Professional Studies.

The author reports no conflicts of interest and is solely responsible for the content and writing of the dissertation.

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Acronyms Used in the Text

BACP: British Association for Psychotherapy & Counselling

BPS: British Psychological Society

CoP: Counselling psychology

DCoP: Division of Counselling Psychology

DoH: Department of Health

DSM: Diagnostic and Statistical Manual

EP: Existential-phenomenological

EPP: Existential-phenomenological practice

EPT: Existential-phenomenological therapy

IAPT: Improving Access to Psychological Therapies

ICD: International Classification of Diseases

NHS: National Health Service

NICE: National Institute of Health and Clinical Excellence

UKCP: United Kingdom Council for Psychotherapy

1. INTRODUCTION

If an existentialist finds it important to do psychotherapy research, or is unaccountably smitten with the urge to do psychotherapy research, we have faith that the existentialist would be able to justify this with their own existential principles. It could be much harder to convince one's colleagues, but that is a separate issue (Mahrer & Boulet, 2004).

Over the last decade there has been a paradigmatic shift in perspective on wellbeing and health in societal, scientific and political spheres and mental wellbeing has been recognised as an important aspect of people's lives (Layard, 2011). As a result, primary care as gateway to mental health care in the UK and the provision of psychological interventions at this level have received a lot of attention (Department of Health, 2011a; National Mental Health Development Unit/IAPT Programme, 2010).

At the same time, there is a growing recognition that an increasingly diverse population accessing psychological interventions requires increased choice and flexibility in terms of service provision (Cooper & Mcleod, 2010): different people need different psychological interventions at different times (Cooper, 2008; Norcross, Beutler, & Levant, 2006). Since 2012, the Improving Access to Psychological Therapies programme (IAPT) is in the process of rolling out a growing diversity of therapeutic models in addition to its initial focus on cognitive-behaviour therapy (Department of Health, 2012).

Existential approaches to psychological interventions, too recognise an emphasis on diversity as a fundamental aspect of psychological therapy (Cooper, 2003). It is argued in this study that practicing from this perspective within the primary care context is potentially valuable in terms of expanding the current service provision.

At the same time, such practice is a complex and under-researched professional task. If the aim is eventually to support an explicit expansion of primary care offerings to include existential therapy, it is necessary to understand in more detail what practicing in this way entails. In order to accomplish this, this study looks at how both novice practitioners and experienced practitioners conceptualise existential therapy in primary care. Specifically, it constructs a theory of the professional task of negotiating existential therapy, including the way practitioners manage any tensions or dilemmas that arise as a result of practicing within a primary care context.

The resulting research report is divided into seven chapters: chapter 1 introduces myself as researcher and defines the terms used throughout the text, before situating this research project within the public sector in the UK in general, the context of primary care in particular, as well as the profession of counselling psychology and the practice of existential therapy.

Chapter 2 develops the argument set out in Chapter 1, with reference to the existing bodies of knowledge. The literature on primary care and the medical model, the British

School of existential therapy and the wider field of existential therapies as well as the literature on the negotiation of practice in different contexts is reviewed. A number of questions are raised which impact on the present research.

Chapter 3 states the aims for the current research project, alongside its objectives and the research question.

Chapter 4 introduces the reader to the epistemological position underlying this research and outlines the resulting stance towards reflexivity that I take. It further outlines my choice of research methodology, introduces Grounded Theory and the procedural steps taken to collect and analyse the data for this study.

Chapter 5 introduces the sample of participants and subsequently puts forward the grounded theory that was developed on the basis of the interview data collected from this sample.

Chapter 6 discusses the grounded theory and the findings of this research in the light of the wider bodies of knowledge and the existing literature.

Chapter 7 concludes the research report by discussing my own response to this research, as well as putting forward some implications for clinical practice and training in counselling psychology and existential therapy.

1.1. Introducing the Researcher

Behind every research project, there is inevitably a researcher. Therefore, research is both a personal and professional narrative. In this case, it is part of my narrative of becoming a counselling psychologist. In order to remain true to this and to be accountable as researcher to the statements I make in this report, I have endeavoured to include an account of my own experience inasmuch as it impacts on or reflects the research process. Therefore, I have included a number of reflective sections that journal the choices I have made in order to produce this research project.

One of the important departure points for my journey to becoming a counselling psychologist and practitioner-philosopher-scientist has been my interest in philosophy and existential-phenomenological philosophy in particular. When I first started training in counselling psychology this interest appeared to me more of an academic nature and I experienced an intellectual giddiness and excitement when debating philosophical questions. However, over time it became clear to me that my own background as migrant from Germany who had lived in a number of countries around the world found in existentialism an important way of grappling with my own roots and identity. Therefore an existential and phenomenological perspective on psychology forms a fundamental part not only of my professional but also my personal identity. This personal relevance formed the basis of my decision to pursue this topic from a research perspective because it presented me with an opportunity to both put my interest to the service of the wider existential community and also further explore my own connection with existentialism and phenomenology.

My starting point for this particular research has been my own lived experience as a trainee counselling psychologist and psychotherapist, practicing in an existentially and phenomenologically informed way in a number of primary care settings.

It is my experience that the concepts and practices that I, and also my colleagues were able to share with clients in these settings have been helpful. Particularly, being able to question and explore some of the assumptions about illness and health that the context of primary care left unreflected on felt a valuable addition to the offer of care. It is my impression, that what I and my colleagues provided was somehow different to what my clients might have experienced previously in primary care or what they were likely to experience had they happened to be referred to a different service.

Therefore, I started to plan this project as a way to articulate my experiences of existential-phenomenological practice in primary care: at first, I was interested in testing and measuring the ‘usefulness’ I experienced through traditional and established forms of enquiry such as outcome and effectiveness research.

However, after an initially creative and enthusiastic phase, I realised two things: firstly, in order to measure something you need to know what it is that you are measuring and I was somewhat unclear about what we, as existential practitioners in primary care, had in common in our practice. Secondly, I realised that my questions about outcomes did not appear to be as important or meaningful to the practitioners around me (or even the

clients I spoke to) as they had appeared to me. Even though, or maybe also because practitioners experienced their work to be useful to clients, they saw this largely in idiosyncratic terms. However, on the other hand, there was a consensus that primary care required a way of working that was difficult to marry up with how we were taught as part of our training and the way that was articulated within the existential literature, practice and culture. What exactly that was remained unclear.

As a result, my emphasis and research interests underwent a shift. If I eventually wanted to articulate how existential-phenomenological practice at primary care level was useful, I needed to get a better idea of the kind of practice that it constitutes, the tensions and dilemmas that practitioners face, and how it could be adapted to the context of primary care. The process of changing the emphasis of this project was fraught with anxiety and the difficulty to find the right language that on one hand retains the rich idiosyncrasies of existential-phenomenological practice while at the same time articulating some of its commonalities. However, towards the end of this project it started to feel like having captured some of the spirit of practicing in this way. I hope that this project will form a part of a fundament that might allow future research to articulate better the contribution that existential-phenomenological practices make to the primary care setup.

1.2. Definition of Terms

Throughout this report the term *existential therapy* has been used to describe the various practices and therapeutic schools associated with existential (and phenomenological) psychotherapeutic and psychological practice.

There are number of definitions or attempts to circumscribe *existential therapy*, some more extensive than others, (e.g., Cooper, 2015; Craig, 2012; May, 1961; World Confederation for Existential Therapy, 2016), which is mostly due to a diverse field with its many different perspectives. For the purpose of this study, I chose Cooper's (2015) definition as it is both concise and up to date. According to Cooper *existential therapies* are therapeutic practices that:

1. Explicitly use the term 'existential' to describe the focus of the intervention
2. Are based, primarily on the assumptions that human beings
 - have a need for meaning and purpose
 - have a capacity for freedom and choice and function most effectively when they actualise this potential and take responsibility for their choices
 - will inevitably face limitations and challenges in their lives and function most effectively when they face up to - rather than avoid or deny - them
 - find the subjective, phenomenological flow of experience a key aspect, and therefore a central focus for therapeutic work
 - and human experience is fundamentally embedded in relationships with others and with its world.

Reference is also made specifically to the British school of existential-phenomenological therapy. This follows largely what Cooper (2003) has termed the British school of existential analysis. As outlined and defined in more detail in the review of the literature, the British School can be differentiated from other existential therapies by its strong basis in both existential and phenomenological philosophical traditions (Cooper, 2003) and a strong tendency towards emphasising the idiosyncratic nature of the therapeutic encounter. The British school originates predominantly from two UK institutions: the School of Psychotherapy and Counselling at Regents' College (now Regent's School of Psychotherapy and Psychology at Regent's University) and the New School of Psychotherapy and Counselling (Ibid).

When making reference to the particular practices investigated in the current research the term *existential-phenomenological practices* (EPP) has been adopted. This was done in order to take account of the diversity of therapeutic practices present among participants while at the same time acknowledging that all participants recruited for this research have trained at one (or both) of the two institutions that predominantly stand in the British existential-phenomenological tradition. It also follows the way the interviewed practitioners make reference to their own work as standing both in existential and phenomenological traditions while incorporating a number of perspectives. While there is published literature on a specific short-term existential therapy in primary care (Rayner & Vitali, 2015) none of the participants makes reference to standing in this tradition and therefore the term has not been adopted in this report.

Primary Care is defined for the purpose of this study as the first point of contact for people in distress, seeking help within the public sector (World Health Organisation, n.d.). This study looks at primary care within the UK only. Specifically in the context of mental health care, primary care includes General Practice, psychological care delivered within, now mostly decommissioned, primary care mental health trusts and the Improving Access to Psychological Therapies (IAPT) programme.

The terms '*patients*' and '*clients*' are used interchangeably in this research and so are the terms '*practitioner*', '*therapist*' and '*clinician*'. I aim however, to follow the way in which different people, such as authors and research participants use these terms.

1.3. Situating the Research

In order to outline the significance of the current research, it appears fundamental to situate it in its wider context. I therefore commence with a brief introduction to the characteristics of primary care, before delving into the significance of existential therapy in this environment and its relevance to counselling psychology and psychotherapy.

1.3.1. The Characteristics of Primary Care

At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time (Department of Health, 2011b). In order to provide help to distressed people, the National Health Service (NHS) as the main public provider of mental health services in the UK has adopted a stepped care model (Bower, 2005). Traditionally, primary care, secondary care, tertiary care provide the main structural level within this model.

For people accessing mental health care, primary care is their first and main access point. Approximately a quarter of all GP consultations are related to a mental health problem (Joint Commissioning Panel for Mental Health, 2012). This puts primary care in a unique position within the UK public health system, the centrality of which has been recognised with the introduction of GP commissioning (Tait et al., 2013). The World Health Organisation (WHO) defines primary care as follows:

Primary care (PC) is more than just the level of care or gate keeping; it is a key process in the health system. It is first-contact, accessible, continued, comprehensive and coordinated care (World Health Organisation, 1978).

A significant proportion of mental health care at primary care level is provided through psychological interventions (Department of Health, 2012). Although primary care's largest programme of psychological therapy delivery, the Improving Access to Psychological Therapies (IAPT) programme, does not report on patient satisfaction (Community and Mental Health Team, 2015), the importance of primary care and psychological interventions at this level is underlined by historically high satisfaction rates (Brettell, Hill, & Jenkins, 2008; Hemmings, 2000) and a preference on behalf of patients for receiving treatment at primary care level as opposed to more specialised services (Alexander, Arnkoff, & Glass, 2010).

However, as a consequence of primary care's positioning as first point of contact for people accessing psychological interventions it is required to attend to a population with a particularly broad diversity (Alexander et al., 2010). The centre for Academic Primary care at the University of Bristol defines primary health care as being based on

caring for people rather than specific diseases. This means that professionals working in primary care are generalists, dealing with a broad range of physical, psychological and social problems, rather than specialists in any particular disease area (University of Bristol, 2015).

Primary care therefore is fundamentally located in a context that requires a paradigm that goes beyond a unitary approach to distress (Alexander et al., 2010; O'Donohue, Byrd, Cummings, & Henderson, 2005). Indeed, both the NHS framework (NHS and Finance Directorate, 2014) and the Department of Health (DoH)/IAPT programme (Department of Health, 2012) recognise the limitations of the service provision and the importance of providing patients with a range of treatment options to suit their individual needs and preferences. Since 2012, one of the IAPT programme's central agenda items is to expand the choice and flexibility of treatments available (Department of Health, 2012).

1.3.2. Counselling Psychology and Primary Care

Consent to treatment and its multitudinous implications rests on the a priori provision of an accurate and comprehensible definition of what is involved in treatment. It would appear that, in relation to Counselling Psychology, charting the territory of the discipline may be far from a frivolous academic luxury, it is perhaps an ethical imperative (Cross & Watts, 2002, p. 6).

The population of professionals currently working in the NHS and primary care, and also their underlying value bases are conducive to facilitating patient choice and responding to patient needs central to the NHS primary care agenda (NHS and Finance Directorate, 2014). Indeed, professionals working in primary care come from a broad range of backgrounds such as nursing, medicine, psychotherapy, and psychology, but also in terms of professional qualifications and personal philosophies (Primary Care Workforce Commission, 2015).

Among these professionals, counselling psychologists specifically form an increasingly prevalent group (Corney, 2003). More than half of the 1400 UK counselling psychologists work in the public sector and many of those in primary care and IAPT services (James, 2013). Training programmes at universities such as Regent's University require trainees to complete at least one placement within the NHS in order to fulfil the training requirements (Regent's University, 2015). Indeed, primary care presents the third largest training placement setting in the UK (Ramsey-Wade, 2014) in terms of number of counselling psychology trainees.

In line with the diversity agenda of primary care, counselling psychology espouses diversity and pluralism (Wilk, 2014) and individualised formulation and treatment as professional values (Division of Counselling Psychology, 2006; HCPC, 2015). Training programmes emphasise a range of different therapeutic orientations as 'core models' such as CBT, person-centred therapy, psychodynamic therapy, integrative therapy and existential therapy (Ramsey-Wade, 2014). Counselling psychologists work, per requirement of their regulating body, with different therapeutic modalities in response to the individual needs of clients. As a result, counselling psychology not only poses an important professional group already practicing in primary care, but is also well-placed to develop the primary care agenda by matching the diverse needs of clients in this setting with a diverse skill set.

1.3.2.1. Existential Therapy : a Counselling Psychology Core Practice

Two out of the thirteen training route programmes in counselling psychology in the UK have existential therapy as a core model (Regents University and The New School of Psychotherapy and Counselling) and a number of other training programmes include existential therapy as one of the taught models (Ramsey-Wade, 2014). As a result, there is a significant number of counselling psychologists trained in this approach.

British existential therapy has been called a particular school within the larger field of the existential therapies (Cooper, 2003; Correia, Cooper, & Berdondini, 2014). It mainly developed in the UK and is characterised by its foundation in existential philosophy and its phenomenological and relational outlook (Cooper, 2015). Compared to other existential therapies, British existential therapy are located on the soft end of what has been called a ‘hard’-‘soft’ dimension (Cooper, 2015, p. 15) that is, they are characterised by their exploratory and client-focussed nature.

Significantly, there is a pronounced overlap between existential therapy and the position that the British version of counselling psychology takes as both derive their therapeutic practices from a phenomenological-humanistic philosophical value base (Moller, 2011) and share important epistemological and philosophical roots (Spinelli, 2003). Indeed, there are voices talking about ‘existential-phenomenological counselling psychology’ (Spinelli, 2014): it has been suggested that apart from being a standalone modality which adds to the choice of models that counselling psychologists can select from when working pluralistically, the existential paradigm provides counselling psychology with an attitude (Milton, Charles, Judd, O'Brien, & Turner, 2002), and a way to “think about the ‘doing’ of counselling psychology” (Spinelli, 2003, p. 193).

According to McAteer, counselling psychology practice demands an awareness of the “philosophical components informing choices we make” (McAteer, 2010, p. 15). Cooper calls counselling psychology “ethics-in-action” (Cooper, 2009, p. 120) which aligns it with the philosophically informed practice of existential therapy. Indeed, existential therapy provides a perspective towards integrating pluralistic practices (Cooper, 2009; Milton et al., 2002) in the sense that it strengthens “our field’s philosophical and ethical stances which attempt to address psychological difficulties as relational rather than medical in nature” (Manafi, 2010, p. 172). Moreover, both counselling psychology and existential therapy take a holistic perspective on human distress emphasising the subjective reality of the client and aiming to be responsive to it (Cooper, 2009). Both offer a contextualised understanding of the client:

This implies not only the socio-political, cultural and historical givens of someone’s existence but also their perchedness between birth and death, bodily existence and spiritual meaning-making, their separateness and connectedness and the moral questions and choices that arise every step of the way in the light of the irrevocability of our actions and the finitude of our lifespan (Steffen & Hanley, 2014 p.3).

As a result, existential and phenomenological perspectives have formed a strong practice within counselling psychology. Despite the absence of any official figures, it can be assumed that a considerable number of existentially trained counselling psychologists work in the NHS and in primary care. Together with my own knowledge of at least five different trusts that employ existentially trained practitioners on either a substantial or honorary level, this leads to the conclusion that a population of existentially informed counselling psychologists exists and is likely to exist for some time to come as more counselling psychologists seek employment in the NHS (Fairfax, 2013; Manafi, 2010).

1.3.2.2. Existential Therapy beyond Counselling Psychology

Beyond its prevalence within the profession of counselling psychology, existential therapy forms a sizeable branch of the profession of psychotherapy in the UK. Existential-phenomenological therapy is taught at six UK institutions, accounting for 4.7% of the world's total existential therapy institutions (Correia et al., 2014). The Society of Existential Analysis, as the professional membership organisation for existential practitioners has 475 members in the UK. In the absence of any official figures it is difficult to determine the number of existential psychotherapists working in primary care however, on the basis of anecdotal evidence from the two largest UK training institutions, the New School of Psychotherapy and Counselling and Regent's University it can be assumed that a number of trainees in psychotherapy spend time training in primary care placements.

1.3.3. *The Contribution of Existential Therapy to Primary Care*

Despite its pervasiveness within UK counselling psychology (Spinelli, 2014) and psychotherapy (Correia et al., 2014), existential therapy is not officially espoused by primary care or IAPT. Neither are they espoused by the NICE guidelines which increasingly dictate service provision in primary care (Leng, Baillie, & Raj, 2010). This might partly be rooted in the fact that the qualities of existential therapy make it hard to operationally define and study (indeed, some have argued this to be a foundational feature of existential therapy (Cohn 1997)). It might also be linked to a tendency, certainly within the British School, towards a reactionary, anti-psychiatry (Laing, 2010) and de-pathologising (Cooper, 2003) perspective, which might bias practitioners against the medical model and might make it difficult to propose openly to work alongside it.

In terms of its guiding principles however, existential therapy arguably sits rather naturally in the context of primary care and the unique characteristics of this setting: first of all, recent research has provided some positive outcomes that inspire a cautious optimism (Rayner & Vitali, 2015). Secondly, existential therapy puts particular emphasis on temporality and limitations of time which might be beneficial within the brief timeframes available in primary care (Robinson, 2005). Thirdly, the phenomenological position inherent in these practice is particularly sensitive to the individual needs of clients. This is essential when catering for a broad and diverse range of needs such as those presenting in primary care (Alexander et al., 2010). Moreover, in the light of the surge of approaches focussing on symptom reduction, such as the version of CBT provided by IAPT, existential therapies' emphasis on meaning-making might facilitate longer-term resilience by helping clients understand the processes that lead to their distress (van Deurzen, 2012).

From my own perspective as practitioner and trainee counselling psychologist and from working within primary care throughout my training, certainly it is my experience that existential therapy adds a valuable contribution to this setting. From conversations with colleagues, both within my training institution and also outside of it, I have experienced a similar sentiment.

1.3.4. Summary: A Case for an Enquiry into Existential Therapy in Primary Care

Psychological interventions within primary care settings provide a backbone to the delivery of mental health care in the UK. As a first point of access for people with mental health concerns primary care caters for a broad diversity of needs. Therefore, the need for expanding the breadth of the current service provision is acknowledged by both the NHS and IAPT as its largest single programme of psychological intervention.

The counselling psychology practice of existential therapy appears to provide a good fit with the primary care context, despite a lack of recognition through official programmes such as IAPT and despite the lack of engagement with this context on behalf of the community of existential practitioners. Indeed, the reality is that both counselling psychologists trained in existential therapy and existential psychotherapists are working within primary care and primary care presents an important setting in the training of counselling psychologists.

However, little research has explored this topic so far. Therefore, research into existential therapy in primary care serves several important functions: most importantly, if practitioners perceive working existential-phenomenologically in primary care to be possible, even within a context that is not explicitly supportive or accommodating of this practice, this is valuable for practitioners who may be under the impression that the NHS, a major employer for therapists and counselling psychologists, is not a place where they can survive and thrive. Findings from this research might help to create the basis for dialogue between those existential practitioners who are sceptical towards the integration of existential therapy into the NHS, those practitioners who might be uncertain about the fit of their philosophical outlook with the public sector settings and those few who advocate for existential therapy in the public sector (Rayner & Vitali, 2013; 2014).

Secondly, if existential practitioners perceive their work not only to be possible but also to be beneficial, this would beg for further research and further gathering of data that might eventually support an explicit expansion of primary care offerings to include existential therapy. The present study might inform and guide such inquiries by providing an initial outline of the nature of this practice.

Thirdly, an inquiry into existential therapy in primary care might help to provide existing practitioners with some practice-based guidance. Indeed, practice-based knowledge on the kinds of practices, tensions or dilemmas that arise as a result of working within a primary care context might provide valuable understandings for the training of future practitioners.

Finally, inasmuch as existential therapy presents an important aspect of counselling psychology practice, the understanding gained from this study contributes to the clinical work that counselling psychologists undertake. This seems especially important given the recent emphasis on practice-based-evidence (Barkham & Mellor-Clark, 2003) which aims

at establishing knowledge about how effective practices can be developed that are of pragmatic value.

In order to critically develop the arguments for this research further, to sensitise this study to the research topic and build potential directions of enquiry, I conducted a review of existing literature and research relevant to the topics discussed above. The results of this review are outlined in the next chapter.

2. REVIEW OF THE LITERATURE

I think there has been far too much emphasis in the existential approach in criticising other approaches and not enough on saying what we offer. And that has created a situation where, uhm, you know, it's almost kind of we are holier than thou. We don't work in the NHS system because we don't want our pure existential approach to be tainted by the medical model. Rather than actually thinking: well, if we think that this model is good for clients and since by far the largest marketplace is the NHS, why aren't we trying to sell the approach we have in this system. And to do that we need to be able to say this is what we do and this is how we do it. And this is what we can offer to these clients (Robert, research participant).

This chapter provides a review of the literature relevant to existential in primary care. As outlined in the previous chapter, reviewing the literature serves three main functions. First of all, it critically grounds the rationale made for this research in the introduction within the existing bodies of knowledge and expands on it. Secondly, it sensitises both the research and the researcher to the topic explored (Bowen, 2006) to thirdly, open up possible lines of enquiry and ultimately, to develop a research question (Lee, 2008).

The review of the literature has five sub-sections: before the literature itself is presented, the methodology for finding and reviewing the literature is outlined. Subsequently, literature on primary care, existential and existential-phenomenological practices as well as literature on the negotiation of counselling psychology practice in medical-model settings is discussed in turn. Literature on the professional development of practitioners is also discussed. Finally, a summary is presented.

2.1. Methodology for Reviewing the Literature

Following from the exploratory nature of this research and guided by the principles of Grounded Theory methodology (c.f. Chapter 4), the underlying philosophy of the search strategies for the review of the literature is both exploratory and iterative: rather than adopting a particular search strategy *a priori*, literature searches were performed iteratively and the search strategies evolved as more of the search area was known.

First of all, the two overlapping strategies berry-picking (Bates, 1989) and snowballing (Ridley, 2012) were employed in order to get an initial perspective of the range of existing literature. Berry-picking and snowballing in this case consisted of following references and footnotes, journal runs, area scanning, and author searching on the basis of publications known to the author. Thereby, the search area was gradually widened and publication relevant to the current project were identified. In discussion with colleagues and

supervisors further sources were identified. Additional publications were added throughout the entire running period of this project on an iterative basis.

Later on in the research process more focussed keyword searches in databases were executed, particularly once the search area was defined more comprehensively. These focussed on existential/phenomenological approaches to practice and the UK. Research databases including Medline (Pubmed), EBSCO (PsycInfo and PsychArticles) and Web of Science were searched in June 2013 with a number of systematically combined search terms. Search terms were combined as follows:

- A. Search terms combined by OR syntax: brief, short*, time-limited
- B. Search terms combined by OR syntax: existential*, phenomenological*
- C. Search terms combined by OR syntax: psychotherapy, therapy*, psychology
- D. Search terms combined by OR syntax: primary care, IAPT, Improving Access to Psychological Therapies, NHS, National Health Service, public sector

Step A, B, C, D were combined by AND syntax in four different combinations, resulting in a different number of results as outlined in Table 1.

Database	A + B + C + D	B + C + D	B + C	A + B + C
Medline (Pubmed)	7	400	4918	120
PsychInfo/PsychArticles	5	64	1018	42
Web of Science	6	113	5135	157

Table 1: Results of the Literature Search

The resulting list of texts were further narrowed down by reading the abstracts and deciding on the basis of this whether a particular texts was relevant to the current study. Relevance was established in the light of my own knowledge of the research topic, the knowledge developed as part of the first part of the search strategy and the supervisory input.

After identifying relevant literature sources, a narrative literature was created. The narrative structure was established through an informal process of identifying themes and also content carrying the potential to contradict or add to those themes. While less systematic, the process followed loosely the steps set out for Thematic Analysis by Braun and Clarke (2006): after familiarizing myself with the sources, I noted interesting features and developed these further into themes which were then developed and reviewed in the light of all the sources. Finally an overall narrative structure was established that tells the story of the literature and this was further reviewed in the light of the emerging overall research.

In addition to literature related to the research topic, literature on research methodologies was also accumulated through berry-picking and snowballing. This process was started with more general textbooks such as Denzin and Lincoln (2005), Willig (2008) and Marks and Yardley (2004) and later supplemented with more specific literature relevant to this particular research, e.g., Charmaz (2006). As a result, Grounded Theory was chosen as research methodology. A more detailed outline of the choice of methodology is given in Chapter 4.

While most of the literature was read and summarised before the data collection and analysis, the literature review was written up after the analysis was completed, in line with Grounded Theory philosophy: this enabled me to present a more relevant and focussed literature review that accommodates any changes in the focus of this project.

2.2. Primary Care & the Medical Model

The search for relevant bodies of knowledge on primary care resulted in a broad range of literature. Within this, two main themes emerge that are relevant to this research.

First of all, and as already alluded to in the introduction, primary care's position in the health care system results in certain demands on the delivery of psychological interventions at this level. It is outlined how research into existential therapy might contribute to fill the gaps in the current service delivery that result from these demands.

Secondly, it is discussed how the philosophical position underlying primary care service delivery impacts on this setting and the possible implications for clinicians practicing in this context are outlined.

2.2.1. *The Characteristics of Primary Care*

As the entry point to the stepped care model, primary care represents the first point of contact for many people in distress. For professionals working at this level this means that the psychological interventions that they deliver are required to cater for a high diversity in terms of patients' backgrounds, the concerns they present and the severity of distress they experience (Alexander et al., 2010). Patients bring a broad range of clinical presentations, from mild common mental health concerns to severe, longer standing and higher risk issues and additional physical conditions (Robinson, 2005), including a high prevalence of comorbidity (Rodriguez, Weisberg, & Pagano, 2004), as well as problem substance use (Alexander et al., 2010; Robinson, 2005). There is a significant prevalence of common mental health issues with greater complexity (Byng & Gask, 2009; National Mental Health Development Unit/ IAPT Programme, 2010) and a high prevalence of medically unexplained symptoms (Steinbrecher, Koerber, Frieser, & Hiller, 2011). This presents a challenge for the existing service provision.

Firstly, over the last decade, an increasing focus has been placed on treatments with the most evidence of efficacy: CBT, Interpersonal Therapy, Brief Dynamic Interpersonal

Therapy (IPT) and counselling (Department of Health, 2012). The advantages of this approach include clear guidance for both professionals and patients on the kind of interventions that should be available and the risk of interventions that are contraindicated for particular problems or pathologies are minimised (Lilienfeld, 2007).

However, the focus on standardisation has created somewhat of a monoculture of interventions (Cooper, 2010; Community and Mental Health Team, 2015): only 30 percent of IAPT's High Intensity Therapists actually deliver non-CBT interventions (Department of Health, 2012). In turn, this limits professionals' ability to respond to the diverse needs presenting at primary care level. Evidence certainly supports the notion that the diversity of patients might be best met with a diversity of interventions. Individual patients, even when they present with the same condition, do not respond equally to a given intervention (Royal College of Psychiatrists, 2008). Other authors point out that relying on a one-size-fits all menu homogenises human distress, thereby eliminating individuality and individual recovery which is particularly important to psychological work as it relies on patients finding personal meaning and coping strategies that match their individual concerns and worries (Mollon, 2009). Moreover, patients tend to take up an offering of choice (King et al., 2000), which in turn has a positive impact on treatment outcome (Swift & Callahan, 2009).

Secondly, the current service provision relies heavily on psychiatric diagnosis to determine intervention structure and both IAPT treatments and NICE guidelines are based on psychiatric classification systems (National Mental Health Development Unit/ IAPT Programme, 2010; NICE, 2014). However, professionals in primary care deliver therapy and psychological interventions to patients that are often "distressed rather than 'mentally ill'" (Corney, 2003, p. 415): presenting concerns are often due to current life circumstances such as relationships with significant others, employment, illness, etc., rather than enduring mental health disorders (Middleton & Shaw, 2000) and there is a high prevalence of sub-threshold mental health issues (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009; Pincus, Davis, & McQueen, 1999). Robinson (2005) notes that for every patient with depression there will be at least one or two with sub-threshold depressive symptoms. Therefore, psychiatric diagnosis might not always fit the unique presenting concerns of patients at primary care level and the question is raised whether interventions developed on the basis of psychiatric diagnosis are appropriate for all patients.

Finally, the manualisation of treatments that has taken place in the wake of the standardisation of interventions do not necessarily translate well into clinical practice at primary care level (Roth & Fonagy, 2006): manualised interventions are not generally designed for the diversity of presenting concerns at primary care level but rather employ strict exclusion criteria to maximise internal validity. Traditionally, evidence-based treatments are designed to be offered at more specialised services at secondary or tertiary care level for three to five percent of the population whereas in primary care treatments need to fit for 20-30 percent of the population (Alexander et al., 2010). Standardising interventions and training (including limiting the scope of previously available interventions) also bears the risk of under-utilising existing skills and de-professionalising clinicians which might lead to less competently delivered care (Fairfax, 2013; James, 2013).

Consequently, there have been calls for an expansion of therapy provision beyond the existing therapy provision of CBT, IPT and counselling: both among practitioners (Cooper, 2010; Guy, Thomas, Stephenson, & Loewenthal, 2011) but also on the level of the IAPT programme itself (Department of Health, 2012). In fact, one of the IAPT programme's central agenda items is to expand the choice and flexibility of treatments available (Ibid). A report on primary care psychotherapies from the Royal College of Psychiatrists from 2008 notes:

More research needs to be directed to improving the quality of therapies provided under ordinary working conditions. This is likely to need to focus on therapists' personal contributions within a treatment model, and the identification of microskills linked with effective practice (Royal College of Psychiatrists, 2008, p. 24).

Therefore, in order match the diversity of patients, both increasing the range of available interventions as well as providing interventions that are sensitive to and can be responsive to a wide range of presenting concerns presents an essential challenge for primary care. Researching interventions that show potential for being able to meet the challenges of a broad and complex patient population, such as existential therapy, is thus an important contribution to primary care.

2.2.2.Philosophical Underpinnings of the Medical Model & Practice Implications

Further to exploring the gaps within the current delivery of psychological interventions at primary care level, it appears important to explore how the philosophical position underlying primary care service delivery impacts on professional practice in this setting. This seems especially pertinent in the light of the value that particularly existential therapies places on the link between their philosophical value base and practice. The aim of this section is to sensitise the research to the kinds of practices and procedures that existential practitioners might encounter in this setting.

Primary care and as a direct result, psychological therapy delivery at primary care level, primarily draws on the tradition of the values of the medical model of the National Health Service (Bloor, Maynard, & Nuffield Trust, 1998; Shah & Mountain, 2007). In terms of its philosophical roots, this particular version of the medical model in turn, mainly relies on a medical-positivist perspective that frames psychological distress in terms of 'mental illness'. In terms of its aims, this model has been framed in terms of technical rationality which "involves the application of criteria of rational decision making, tied to calculable economic efficiency, into increasing areas of social life and is closely associated with the rise of industrial capitalism" (Woolfe, Dryden, & Strawbridge, 2010, p. 15). This means that the work of professionals such as psychologists and psychotherapists is seen as mostly analogous to medical treatment to restore optimal health and functioning (House, 2012).

The rootedness of primary care in this model is perpetuated by the increasing dominance of guidance through the National Institute for Health and Clinical Excellence (NICE)

(Guy et al., 2011). Thereby, NICE establishes a de-facto standard which is monitored for compliance by regulators such as the Care Quality Commission (Care Quality Commission, 2015).

The IAPT programme is equally founded on the economic argument that an investment in psychological therapy provision will lead to a decrease in the expenditure on incapacity benefits and to a society-wide increase in wellbeing (Cohen, 2008). IAPT has the articulated aim of securing “sustainable and equitable access for at least 15 percent of the local adult population in need of effective evidence-based psychological therapies and a 50 percent recovery rate among those completing treatment” (Department of Health, 2012 p.11).

These developments have created an approach towards the ‘management of care’, namely homogenisation, standardisation, measurability, risk- and harm management, and a move away from individual clinical autonomy towards institutional policies and procedures and quality insurance initiatives. In practice, this means that intensity, type and duration of interventions aims to be objectively determined by clinical procedures rather than based on subjective clinician’s judgement. As Marks (2002) puts forward:

When the name of the game is something like ‘clinical governance’, ‘health improvement’, ‘modernisation’, ‘systematic reviews’ and ‘evidence reviews’, who could possibly be against it? (p. 18).

The *modus operandi* of psychological interventions that follows from managed care becomes especially evident in four aspects of primary care: the limitations on intervention duration, the adopted model of pathology, the version of evidence-based practice that primary care service delivery calls for and the way interventions are increasingly structured.

2.2.2.1. Time Limits

As first point of contact primary care faces a high demand for psychological therapy. In the wake of the IAPT programme patient numbers have increased from 160 000 per year in 2007 (Barnes & Hall, 2008) to over one million patients in 2013 (Department of Health, 2012). This has led to the increasing introduction of the stepped care model (Pilling, Whittington, Taylor, & Kendrick, 2011) in primary care. The stepped care model (Bower, 2005; Richards et al., 2012) follows the notion that interventions for mental health problems should be least intensive in terms of staff time, cost of delivery and patient involvement. Traditionally, steps at primary care level (steps 1-3) are broader and more generalised.

In practice this means that interventions at primary care level are predominantly characterised by limited, brief time frames. Clinicians at primary care level provide interventions that typically consists of 4-12 sessions with limits on extensions (Robinson, 2005). Research evidence suggests that brief psychotherapies at primary care level are indeed effective (Gilbert, Barkham, Richards, & Cameron, 2005; King et al., 2000;

Shepherd et al., 2005) and often the transitory nature of clinical presentations at this level might not warrant longer-term interventions. At the same time, brief interventions do not deliver the same long-term resilience as longer interventions (Knekt, Lindfors, & Saare-Jäske, 2013) which raises the question of how brief interventions can develop in this area. Further, working with very limited timeframes provides unique challenges to clinicians such as managing patients' desires to be 'cured' within short periods of time and balancing problem-focus with exploration (Hudson-Allez, 1999; Lyons & Low, 2009).

Therefore, clinicians and interventions at primary care level are likely to benefit from sensitivity towards time and time limits. Researching such interventions, for example existential therapy, is thus an important contribution to primary care. Further, clinicians working in the primary care setting are likely to encounter time as an element of their therapeutic work with clients and therefore it is important that research takes this into account.

2.2.2.2. The Medical Model of Pathology

Analogue to the treatment of physical illness, the treatment of psychological 'illness' at primary care level mostly follows a normative classification system. Psychological care at this level relies mainly on diagnostic labels to determine treatments such as those espoused by the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2014) or the International Classification of Diseases (World Health Organization, 1992). Historically, these two main classification systems have developed analogues to medical disease classification systems (Fletcher, 2012) and are based on positivist assumptions of 'normality' that is accessible to the diagnosing clinician and that place 'faulty functioning' within the individual and largely to the exclusion of any social and cultural context (Crowe, 2000). On an institutional level (i.e. through NICE), the use of these classification systems are perpetuated through the publication of guidelines which put forward those psychological interventions which have the most positive impact on the symptoms associated with each diagnosis (Leng et al., 2010). As the NHS, including its workforce is monitored for compliance with NICE guidelines, diagnostically-driven intervention designs form a central feature of clinician delivered psychological interventions.

Organisationally, the adoption of standardised diagnostic labels offers a consistent approach to treatment allocation, clear referral pathways and a multi-disciplinary approach. For example, diagnosis such as anxiety disorders and mood disorders are often treated at primary care level, whereas more complex presentations such as personality disorders and psychotic disorders are mostly referred to more specialised services (Bower, 2005). Therefore, diagnostic labels function as important access criteria for the allocation of interventions. They also determine funding streams, as services are predominantly clustered around treating patients with particular diagnoses (Freeth, 2007). On an individual level, diagnostic criteria can be reassuring to both patients and clinicians as they spell out the kinds of interventions that should be applied and might help clients to

normalise their distress. On a wider societal level, the recourse to diagnostic labels provides clarity amid the messy reality of psychological distress (Fletcher, 2012).

However, clinicians also experience the flip-side of this: indeed, the usefulness of psychiatric diagnosis has been questioned by a broad range of practitioners (Guy et al., 2011; Larsson, Brooks, & Loewenthal, 2012; Middleton & Shaw, 2000). The reasons for this include the lack of evidence-base and indeed the lack of validity of the unique categories put forward by the DSM or ICD (Guy et al., 2011; Westen, Novotny, & Thompson-Brenner, 2004). Research found for example, that DSM axis 1 disorders show large co-morbidity with other Axis 1 or Axis 2 disorders (Westen et al, 2004). Validity might further be skewed because the participant selection of large scale research excludes a significant percentage of patients due to co-morbidity (Ibid). Especially within a primary care environment psychiatric labels do not always fit with the diverse, co-morbid, sub-threshold and often transitory nature of presenting concerns and individual experiences at primary care level. Practitioners have also voiced concerns about the increasing ‘medicalisation’ of distress (Kelly & Rhodes, 2013) and the potentially stigmatising effects within community-delivered services (Fletcher, 2012) where close social networks exist. Indeed, there is an increasing recognition from the psychological professions, that individualised case formulations might provide a better match between individual distress and psychological interventions (Division of Clinical Psychology, 2011; Fletcher, 2012).

Practitioners in primary care therefore have to manage the complex professional task of working with diagnostic labels within the organisational structures of primary care and attend to the individual concerns and needs, especially in instances where these might not overlap. This might be especially pertinent for existential practitioners with their philosophical grounding in humanist and phenomenological traditions which traditionally prioritise individual formulations over diagnostically-driven work.

2.2.2.3.Evidence-based Practice & Measurement

Clinicians at primary care level are increasingly expected to adopt a particular version of evidence-based practice: initial diagnosis is followed by the prescription of a specific dose of a particular intervention that is based on evidence from research trials. The underlying epistemology relies heavily on positivism and positive realism (Marks, 2002). The researcher’s task is to make accurate observations about objective reality, ensuring that error and bias are eliminated by isolating variables in order to be able to identify cause-effect relationships. Therefore, ‘gold standard’ evidence is privileged over other kinds of evidence. While there is little evidence for the superiority of evidence-based practice (Marks, 2002), the arguments behind this approach are increasingly pervasive. Indeed, NICE puts forward a hierarchy of evidence according to which higher value evidence is the kind of evidence from controlled trials and meta-analysis of these trials with non-experimental evidence and clinical expertise presenting the least valued types of evidence (NICE, 2006).

In practice, this means that clinicians are often required to supplement their clinical judgment through the use of psychometric measures. In primary care these frequently

involve measurement systems such as the Outcome Questionnaire System (Lambert, Hansen, & Harmon, 2010) and the CORE-OM system (Barkham et al., 2010b; Mellor-Clark, Connell, Barkham, & Cummins, 2001) which are designed to measure levels of psychological distress and outcome of psychological therapies, the PHQ-9 depression scale (Kroenke, Spitzer, & Williams, 2001), the GAD-7 anxiety scale (Spitzer, Kroenke, Williams, & Löwe, 2006), the social adjustment scale and a range of other psychometric measures (National IAPT Programme Team Mental Health, 2011). These measures are both used to measure session-by-session outcomes (Barkham et al., 2010b) as well as overall therapy effectiveness. Especially, session-by-session measurements have been advocated as a tool to monitor therapy progress, flag risks early and provide patients with feedback of treatment success (Barkham et al., 2010b; Bower & Gilbody, 2010).

Research on the experience of using psychometric measures is sparse (Ashworth, Robinson, & Godfrey, 2005; Corrie & Callanan, 2001; Martin, Hess, Ain, & Nelson, 2012) however there are indicators that collecting measurements impacts on the process and structure of therapy: patients might feel reassured by the science behind measures but also they might be sceptical towards measuring distress in terms of scores and numbers. Equally, clinicians might value the continuous feedback on therapy. On the other hand, they might feel scrutinised and might feel that having to collect measures impacts negatively on the time they have available and moves the attention away from individual change processes to universally accepted ‘outcomes’. Therefore, clinicians might need to manage patient expectations as well as their own responses to being in an ‘evidence-based’ environment, particularly those clinicians that draw on humanist-existential traditions that emphasise idiosyncratic human experience.

2.2.2.4. Manualisation & Therapy Structure

The way in which psychological interventions within the medical model are seen as mostly analogous to medical interventions means that intervention structure is similarly seen in terms of their medical equivalent: assessment, diagnosis, problem formulation and working towards solving problems increasingly forms part of what is expected of psychological interventions within primary care (NICE, 2014). Indeed, psychological interventions such as CBT and IPT are increasingly manualised to this end. As Wilson (2007) points out, treatment manuals help to reduce reliance on intuitive clinical judgment that might vary between clinicians, with less experienced clinicians making poorer clinical calls. It can also support training and supervising clinicians in specific clinical strategies and techniques and a number of self-help interventions with good clinical outcomes have been derived from manual-based protocols. Further, it supports the use of specific techniques and approaches that have been established as successful (Eifert et al, 1997).

On the other hand however, *a priori* intervention structure might also lead to certain expectations: referrers, patients and possibly also clinicians, especially less experienced ones, might expect or demand that interventions should follow the outline that many manualised treatments espouse, even when client presentations, client preferences or the clinician’s judgement are not in line with this. In practice this means that clinicians might

find themselves negotiating the expectations created by the medical model with the requirements of real-world practice. Especially those practitioners whose theoretical orientation holds some scepticism towards a priori structures might be faced with dilemmas in primary care.

Overall, in the light of recent developments such as the introduction of NICE guidance and the launch of the IAPT programme, primary care has benefited from an unprecedented focus on mental health treatment, including financial, research and service provision, with vast amounts of financial, scientific and political resources being made available (Cohen, 2008). On the other hand, the version of the medical model and managed care that is increasingly adopted in primary care impacts on the way clinicians practice in this environment: often, individual clinical autonomy is de-emphasised (Fairfax, 2013; James, 2013) which might lead to processes of negotiation in professional practice. Especially those clinicians that place a high value on the contribution of subjective, intersubjective and relational aspects to therapy, might stand in the tension between relying on established protocols and procedures on one hand and using their own clinical judgment on the other hand. As House (2012) argues, there are substantial “difficulties of values-incongruence for any non-Cognitive Behaviour Therapy (CBT) counsellor now working in an NHS GP milieu”. For the present research, this raises the question whether and how this might play out in practice as it potentially impacts on the successful integration of existential therapy into the primary care context.

2.3. Existential Therapies

How much longer, for example, can existential therapy afford to maintain the position of an elite, underutilized movement? [...] Finally, how much longer can existential theorists justify informality, obscurity, and disunity simply to oppose rigidity? (Schneider, 2008, p. 3)

Among the psychological interventions, existentially informed practices claim a unique territory by explicitly drawing on philosophy in addition to psychological bodies of knowledge. The following section provides a historical account of the development of the existential therapies as well as an overview of the current models of existential practices in relation to the medical model. Subsequently, it situates the British version of existential therapy within the wider field of the existential therapies and outlines both the contributions that this form of practice potentially brings to primary care as well as the challenges practitioners are likely to face.

2.3.1. The Historical Development of the Existential Therapies

Historically, continental existentialism and phenomenology in the late 19th and 20th century developed partly in response to essentialist stances (such as positivist science), which see the human being and the world in terms of abstract and universal objectively measurable essences. Such essentialist perspectives aim at studying the human being in

terms of underlying rules and laws by breaking them down into constitutive parts such as stimuli and response, id and superego, emotions, thoughts and physiological processes. Existentialism and phenomenology on the other hand, focus on the particular and concrete existence and pose its irreducibility to essential components and qualities. They look at understanding the totality of concrete and particular human beings and the meaning human beings make of their circumstances (Spinelli, 2005; 2007).

From these antecedents existential and phenomenological concepts have found their way into a number of fields, including sociology (Tiryakian, 1965), social work (Lantz & Walsh, 2007), psychiatry (Jaspers, 1964; Laing, 2010), coaching (van Deurzen & Hanaway, 2012) and psychoanalysis (Friedman, 1964).

However, especially in the fields of psychology and psychotherapy (Frankl, 1963; Merleau-Ponty, 1962; Spinelli, 2007; Yalom, 1981) existential approaches grew to be a relatively minor, yet important force besides psychoanalysis, humanistic and cognitive/behavioural perspectives (Cooper, 2003). Overall, the existential therapies are characterised by their great diversity. Rather than a clearly delineated orientation, they have been described as a “rich tapestry of intersecting therapeutic practices” (Cooper, 2003, p. 1): starting with Ludwig Binswanger who expanded on what he felt to be the limitations of psychoanalysis, Daseinsanalyse started to integrate existential and phenomenological concepts in the 1930s. Binswanger and later also Medard Boss were inspired by the philosophy of Martin Heidegger which resulted in the Zöllikon Seminars (Cohn, 2002), a series of lectures linking philosophy to therapy. In parallel, Victor Frankl developed Logotherapy on the basis of his experiences in the Nazi concentration camps (Frankl, 1963). The American existential-humanistic approach was developed on the writings of Rollo May (1961) and later Irvin Yalom (Yalom, 1981) as well as Kirk Schneider (Schneider, 2008) and others. Finally, the British School of existential therapy developed in the UK on the basis of Emmy van Deurzen’s work and the contribution of a number of influential writers such as Ernesto Spinelli and Hans Cohn¹ (Cooper, 2003). Compared to other existential therapies, the British School, has been argued to be “softer” or “gentle” (Cooper, 2015, p. 15) in that it draws on the phenomenological method in an exploratory, open and curious fashion, is fundamentally client-focussed and eschews therapeutic ‘techniques’, directive interventions as well as taking a de-pathologising stance (Cooper, 2003).

As outlined in the introduction, the British existential-phenomenological therapeutic thinking also provides a fundamental philosophical and practical basis for UK counselling psychology (DCoP, 2011). Many existential-phenomenological practitioners are also counselling psychologists, for example Emmy van Deurzen, Ernesto Spinelli, Del Loewenthal and Martin Milton.

¹ For a more comprehensive discussion of existential-phenomenological therapies, Cooper (2003) provides a broad overview and detailed description of different schools of existential thought.

2.3.2. *Existential Therapies: Entering a Dialogue with the Medical Model*

While the focus of this research is the UK context and the British school of existential therapy, it appears important to place this practice within the wider realm of the existential therapies, especially in the light of a lack of clear lines of demarcation between the overlapping practices of the different schools of existential therapy (Cooper, 2003). Moreover, this allows the research focus and the questions it asks to be more broadly informed. Having trained within the UK context and being rooted within the British School, it was certainly very useful for me personally to approach the research topic with the awareness of the pluralistic perspectives within the existential therapies (Cooper, 2015) as it helped me become aware of my own biases and assumptions as well as the kinds of questions this research can usefully ask.

While the many developments and published literature within the schools of existential therapy are beyond the scope of this review, particularly over the last decade, there appears that there is an increasing response to the demands of managed care within the public sector: namely, there appears to be a growing focus on brief, structured and specific interventions backed up by systematic evidence. In 2003, Cooper listed exactly two short-term models in his authoritative book on the existential therapies (Cooper, 2003). Since then there has been a surge of publications, the present review found 14 more or less clearly demarcated approaches to working with less than 25 sessions (with individuals, families and groups) across different existential schools such as Logotherapy (Breitbart et al., 2010; Crumbaugh & Carr, 1979; Lantz & Walsh, 2007; Lee, Robin Cohen, Edgar, Laizner, & Gagnon, 2006b; Zuehlke & Watkins, 1977), the American Existential-Humanistic approach (Fegg et al., 2013; Kissane et al., 2004; Spiegel et al., 1999; van der Pompe et al., 2001), the British School (Langdridge, 2006; Rayner & Vitali, 2015; Strasser & Strasser, 1997) and more eclectic perspectives (Maunder & Hunter, 2004).

The existential approaches developed outside the UK appear less focused on symptoms but rather on providing clients with ways of establishing meaning and purpose (Cooper, 2003). Yet, there is a range of literature dedicated to specific presentations (Vos, 2016b; Vos, Craig, & Cooper, 2015b). Particularly in the field of physical health care and palliative care, a number of existential models of therapy have been developed over the past few years (LeMay & Wilson, 2008; Vos, 2016a). Examples of those are Meaning Centred Group Intervention (Breitbart et al., 2010; Greenstein & Breitbart, 2000), Experiential Existential Group Therapy (van der Pompe et al., 2001), Meaning Making Intervention (Henry et al., 2010; Lee, Robin Cohen, Edgar, Laizner, & Gagnon, 2006b), Existential Behavior Therapy (Fegg et al., 2013), Supportive Expressive Group Therapy (Spiegel et al., 1999; Spiegel & Spira, 1991), and Cognitive Existential Group Therapy (Kissane et al., 2004).

Six of these models are manualized and hence structured to varying degrees (Breitbart, Gibson, & Poppito, 2004; Fegg et al., 2013; Lee, Cohen, Edgar, & Laizner, 2006a; Spiegel & Spira, 1991; van der Pompe et al., 2001) paralleling the wider shift in the field of the psychological treatments, towards treatment manuals (LeMay & Wilson, 2008). Notably, however there is a differing degree of structure even within the manualized treatments.

Interventions such as the meaning making intervention (Breitbart et al., 2010; Greenstein & Breitbart, 2000) and Cognitive-Existential Therapy (Kissane et al., 2004) and Existential-Behaviour Therapy (Fegg et al., 2013) are highly structured with detailed manuals and more didactic in nature. The Experiential-Existential group therapies (van der Pompe et al., 2001; Vos, Visser, Garssen, Duivenvoorden, & de Haes, 2007) on the other hand, while manualized and with a fixed session structure, do not predetermine a fixed scheme of topics and offer more phenomenological interventions based on the group process.

It is notable that many of the emerging approaches from outside the UK tend to be integrative in the sense that they make use of therapeutic tools, techniques and frameworks from other traditions such as psychoanalysis (Dowling, 2003) cognitive therapy (Kissane et al., 2004; Lee, Robin Cohen, Edgar, Laizner, & Gagnon, 2006b), behaviour therapy (Fegg et al., 2013), attachment theory (Maunder & Hunter, 2004), meditation and relaxation (Vos et al., 2007), narrative approaches (Garlan, Butler, Rosenbaum, Siegel, & Spiegel, 2010) cybernetic systems (Anchin, 2003) and psycho-education (Dowling, 2003).

Especially the more structured interventions incorporating psycho-education, exercises, and discussing meaning in life show some positive outcomes in domains such as meaning-in-life, psychopathology and self-efficacy (Vos, Cooper, Correia, & Craig, 2015a; Vos, Craig, & Cooper, 2015b). In addition, the development of a number of tools (Kahn & Juster, 2002) such as the Purpose in Life Test, Seeking of Noetic Goals Test (Melton & Schulenberg, 2008), the Meaning in Life Questionnaire (Steger, Frazier, Oishi, & Kaler, 2006), Ryff's wellbeing scales (Ryff & Keyes, 1995) has taken place, which are specifically geared towards evaluating therapy outcomes for these approaches.

While there is no literature specifically on the primary care setting, the focus on issues relevant to this setting such as brief timeframes, a focus on meaning-making in a broad variety of presentations and the integration of diverse perspective might serve as a basis for a successful translation to primary care. The overall positive outcomes of the existential approaches seem equally supportive of this. Further, the surge of existential approaches, many of which are seemingly comfortable with notions such as evidence-based practice, standardisation, cross-modality integration and pathology-focus might be taken as an indication that the existential therapies are looking for a dialogue with the medical model, despite historical differences (Cooper, 2003; Rowan, 2001; Spinelli, 2007).

On the other hand, the way in which the existential therapies seek this dialogue appear largely reactive to the demands of managed care and surprisingly little reflexive of the potential implications. Possible challenges, such as clients (or practitioners) not identifying with the proposed focus, the given exercises or the ways in which progress and outcomes are measured (Westen, 2002; Wilson, 2007) remain unarticulated. None of the more operationalised models make explicit their procedures for managing such ruptures. Therefore, while the reviewed literature from beyond the UK provides encouragement for the fit of the existential therapies with the primary care context, it also raises questions about the implications in actual practice.

2.3.3. The British Perspective: An Idiosyncratic Encounter

It seems therefore that a tension exists between the conceptualisation of existential-phenomenological therapy as unique/individualised practice or as an approach with accepted procedures and protocols (Wilkes & Milton, 2006 p.72).

Within the realm of existential practices, the UK has historically had a strong tradition and has seen the development of the British School of existential-phenomenological practice (Cooper, 2003; Correia et al., 2014).

Different to other existential schools, the British School draws equally strongly on both its existential and phenomenological roots (Cooper, 2003; Walsh & McElwain, 2002). Given that the notion of anti-essentialism plays a dominant role within these traditions, it is unsurprising that at the core of existential therapy stands a critical attitude towards any all-encompassing theory as well as a strong tendency towards emphasising the idiosyncratic nature of the human encounter (Spinelli, 2005): idiosyncratic, lived-experiences are given preference over the general and 'objective'. Historically, existential-phenomenological practitioners have been somewhat reactive towards other models of psychotherapy, rather than being concerned with creating a coherent body of knowledge and practice (Cohn, 1997; Vos, et al, 2015). As du Plock points out, "there are as many ways [to practice existential therapy] as there are practitioners" (du Plock, 1997 p.5).

Hence, as summarised succinctly in Cooper's dimensions of existential practice, British existential-phenomenological therapy tends towards being non-directive, spontaneous rather than technique focussed, descriptive rather than explanatory as well as rejecting the notion of normative pathologies (Cooper, 2003). This 'hard' stance towards its philosophical principles (Cooper, 2012) results in a number of practice implications and raises a number of questions relevant to the context of the current research.

2.3.3.1. Context & Practice Settings

Particularly, context and the relationship of people to contextual aspects are given a strong prominence within the British existential-phenomenological position. Spinelli argues:

We cannot, therefore, understand or make sense of human beings – our selves included – on their own or in isolation, but always and only in and through their inter-relational context (Spinelli, 2007, p. 12).

Overall, British existential-phenomenological therapy focuses on the way clients relate to different aspects of their world as for example outlined in van Deurzen's four dimensions of human existence, the physical, social, personal and spiritual realms (Umwelt, Mitwelt, Eigenwelt and Überwelt) (Van Deurzen, 2009; van Deurzen, 2012). Indeed, there are a wide variety of texts looking at how clients and therapists relate to their contexts such as the NHS (Tantam & Kumar, 2009), intensive care (Barnett, 2009), acute hospital ward (Steel, 2010), being in prison (Weixel-Dixon, 2009), being in relationships (van Deurzen &

Tantam, 2005), forming part of families (Stadlen & Stadlen, 2005), being part of groups (Tantam, 2005), as well as relating to one's own the body (Madison, 2015).

However, the engagement with context is usually framed in terms of how the individual and unique practitioner meets the needs of the individual and unique client in an unique context (Cooper, 2015). In practice, this means that the direction, focus and any adaptations to the therapeutic framework as well as the therapeutic methods the therapist employs are largely idiosyncratic (Oliveira, Sousa & Pires, 2012).

From the perspective of clients' diversity of presenting concerns, backgrounds and experiences in the setting of primary care, this flexible focus on how clients relate to their *situatedness* within contexts, therefore might provide a valuable addition to more structured psychological interventions. This also fits with primary care's acknowledgement of patient choice as it allows for a space to scrutinise the way in which psychotherapy is realised between themselves and their therapist.

On the other hand, the scepticism towards generalising the idiosyncratic therapeutic encounter beyond the particular therapy room has meant that only a handful of authors within the community of existential-phenomenological practitioners pay attention to those contextual aspects that might be common across settings (Barnett, 2009; Rayner & Vitali, 2013; Steel, 2010; Tantam & Kumar, 2009; Weixel-Dixon, 2009). Hence, few attempts have been made to devise specific adaptations of existential-phenomenological therapy for particular contexts i.e., public sector settings.

The literature search found only two more elaborated models that aim at developing an existential-phenomenological response to a particular context: Strasser and Strasser's approach (1997) focuses on working within settings where limitations on time are placed on therapeutic working. They propose a modular working model with several courses of short-term therapy. While Strasser and Strasser seem to aim their model mostly at practitioners in private practice settings or charitable counselling settings, Rayner and Vitali (2015) put forward 'Existential Experimentation', a model of existential therapy within primary care. Conceptually, Rayner and Vitali draw on Spinelli's relational perspective (Spinelli, 2007) and structurally, they draw on the work of Lantz (Lantz & Walsh, 2007), who puts forward a short-term existential intervention based on a social work model for crisis intervention. Existential Experimentation aims:

to explore the individual's attitudes, values and beliefs and how these impact upon the manner in which difficulties are interpreted; b) to challenge the notion of disability and illness and think of distress and recovery; c) to elucidate the person's concerns and to help the person set his or her own goals for therapy; d) to supervise, to motivate and to facilitate the process of experimentation session-by-session and to help the patient reflect upon the meaning of those experiences with respect to the Self and World lived in everyday; e) to support the patient while reflecting on the new experiences and to encourage a careful and sensitive experimentation of a newly discovered sense of Self and wellbeing; f) to support the patient while assessing themselves and the therapeutic experience with respect to the goals that they have set at the beginning of therapy (Rayner & Vitali, 2015, p. 3).

Interestingly, particularly therapists practicing within the environment of the NHS (Barnett, 2009; Rayner & Vitali, 2013; Steel, 2010; Tantam & Kumar, 2009) attest this setting to have a particular impact on their therapeutic work by virtue of standing within the medical model. Some therapists in Wilkes and Milton's research (2006) talk about adjusting the structure of their practice to account of the importance that limitations of time, assessments and risk management procedures in primary care have. Rayner and Vitali (2013; 2015) argue that primary care as practice context makes three main demands on psychological interventions: it poses limitations in time, demands an exploration of the concept of pathology and mental illness and asks for quantitative evidence similar to the evidence provided to officially recognised IAPT interventions (Rayner & Vitali, 2013). In response, they put forward “not a standardised model but one that is operationalized [sic]” (p.15) that is, Existential Experimentation is goal-focussed, has psycho-educative elements and has a predetermined session structure with five therapy sessions and one assessment session. Rayner and Vitali acknowledge that there is a potential tension between the organisational demands of the NHS and the existential-phenomenological attitude of staying with the clients' experiences (Rayner & Vitali, 2014) however, their account does not focus on how this tension is managed on a practical level.

Overall, the sensitivity to contextual aspects beyond the individual client potentially allows existential-phenomenological therapy to work well with the diversity of client presentations in primary care. However, at the same time, the existing literature raises the question whether practice settings, in particular practice settings within the environment of the NHS and primary care have implications for the way practitioners frame and structure their work. Further, the question is raised whether the emphasis of existential-phenomenological therapy on the idiosyncratic client-practitioner context stands in tension to the kinds of demands that these settings make.

2.3.3.2. Time & Time-limits

As previously discussed, time and time-limits form an important contextual aspect of the primary care setting (Rayner & Vitali, 2014; Robinson, 2005). From an existential-phenomenological perspective, too time plays not only an important but a fundamental role in the therapeutic enterprise. Philosophically, existential-phenomenological thinking acknowledges that meaning as a fundamental basis for psychological wellbeing is created in the light of our finiteness (Cohn, 2002; e.g. Spinelli, 1997) and thereby posits a fundamental relationship between well-being and time. As a result, existential-phenomenological therapy places importance on the finiteness of the therapeutic encounter and the implications this might have for the way the work needs to be structured (Cohn, 2002; Lamont, 2012; Rennie, 2006; Strasser & Strasser, 1997).

At the same time, existential-phenomenological practitioners traditionally have shown a tendency to be somewhat critical of brief, short-term and even time-limited approaches (Cooper, 2003). As van Deurzen writes, there are no quick and easy answers to life's challenges (van Deurzen, 2002).

Yet, there are three concrete approaches to time-limited practice in the literature: Strasser and Strasser (1997) suggest that short-term approaches are more than a condensed and incomplete version of longer term models and present a valuable approach in themselves. They argue that the clearly circumscribed frame of short-term working reduces the potential for dependency of the client and facilitates clients' seizing of their freedom of choice. Strasser and Strasser argue that the urgency that is created through the limited time helps to focus the therapeutic effort for both client and therapist. The structure of the therapeutic work emerges for Strasser and Strasser from this urgency and gives more important or salient client concerns the focus they require. Therefore they do not put any emphasis on goal setting at the outset of therapy but rather posit that important themes emerge organically as part of the therapeutic process.

Langdridge (2006) in his sketch of an integration of existential-phenomenological therapy and solution-focussed therapy takes a position somewhat contrary to Strasser and Strasser: Langdridge argues to meet the limitations of time through a focus on particular and clearly delimited concerns and a goal-orientated way of working. He emphasises the importance of providing the most efficacious way to solve clients' concerns from a practical but also an ethical perspective that acknowledges the clients' suffering and the potential lack of other forms of help. Indeed, Langdridge criticises Strasser and Strassers' approach for having "remarkably little" (p.360) to distinguish it from open-ended work. Langdridge proposes the introduction of solution-focussed therapeutic concepts to brief existential-phenomenological therapy which allows the treatment to focus on future problem solving strategies rather than past problems or even present concerns and to provide an efficacious use of the limited time.

[...] the therapist seeks to work with the client to identify 'skeleton keys', solutions that fit not only the immediate presenting concern but also potentially many other problems (Langdridge, 2006, p. 359).

Similarly, Rayner and Vitali's model (2013; 2015) adapts to the limited time available in primary care, proposing a six-session approach, which aims to be facilitated by an early and pro-active goal-setting. Different to other models, Rayner and Vitali propose for each session to have a flexible yet circumscribed function: the initial assessment "provides a form of psycho-education about the process of therapy, the measurement tools we will use and we initiate the engagement with the clients' goals for therapy"(p14). Further sessions aim to facilitate a phenomenological exploration of clients' concerns and are followed by an experimentation with clients' new-found sense of self. Similarly, Wilkes and Milton (2006) report some therapists that work in short term settings, particularly GP surgeries work more structured and focussed, including written assessments.

If the models of Strasser and Strasser, Langdridge and Rayner and Vitali are taken as indication, the sensitivity of British existential-phenomenological therapy to time can be translated particularly well into models that operate within brief timeframes such as primary care. However, the literature also shows that there are a number of different perspectives that can be taken towards the nature of this translation. The fact that different authors take differing positions of how to work within brief timeframes, raises questions with regards to the criteria that should be employed by practitioners in primary

care to decide on the kinds of adaptations that might be necessary compared to ‘standard’ existential-phenomenological therapy.

2.3.3.3. Presenting Concerns & Psychopathology

Another contextual aspect relevant to primary care is the client presentation. There is a wide range of literature on the application of existential-phenomenological concepts to different client presentations, often illustrated with case studies of particular clients. These include: human development (Adams, 2014; Kirby, 2005), HIV (Milton, 1994), sexuality (Pearce, 2011; Smith-Pickard, 2006; Smith-Pickard & Swynnerton, 2005; Spinelli, 1997), eating problems (Schneider & Fitzgerald-Pool, 2005; Thomas, 2001), addiction (du Plock & Fisher, 2005), death (Cooper & Adams, 2005), relationships (van Deurzen & Tantam, 2005), families (Stadlen & Stadlen, 2005), groups (Tantam, 2005), dreams (Young, 2005), purpose (Weixel-Dixon & Strasser, 2005), young offenders (Weixel-Dixon, 2009), trauma (Corbett & Milton, 2011), anxiety (Kirkland-Handley & Mitchell, 2005; Rayner & Vitali, 2015; Strasser & Strasser, 1997), depression (Arnold-Baker, 2005; Rayner & Vitali, 2015) and bereavement (Madison, 2005). Especially, the latter ones, that is anxiety, depression and bereavement are particularly relevant to the setting of primary care (Alexander et al., 2010; Robinson, 2005).

The breadth of applicability of British existential-phenomenological therapy seems to provide a good match with the diversity of client concerns found at primary care level. The phenomenological way of working (Spinelli, 2005) places special emphasis to subjectively experienced phenomena over *a priori* theoretical and normative models of psychological distress, psychopathology such as those underlying the DSM or ICD (Spinelli, 2007). It is argued that de-pathologising these concerns might help to engage hard-to-reach groups that feel stigmatised by psychiatric diagnosis (Cooper, 2003). The emphasis of the existential-phenomenological perspective on exploring (Spinelli, 2005), rather than reducing or explaining distress might help clients to understand the processes that lead to their concerns. This might facilitate resilience and maintain wellbeing in the longer term (Hickes & Mirea, 2012) which might present an important addition to primary care’s range of psychological interventions largely focussed on symptom reduction.

At the same time, existential-phenomenological practitioners are often highly critical of the medical model of psychopathology (Cohn, 1997; Spinelli, 2007). Overall, there appears little engagement with the reality that more clearly circumscribed models of client presentations, such as models of psychopathology and psychiatric diagnosis are a reality in primary care sector and often determine access to services. No literature was found that explores such models of psychopathology in relation to existential-phenomenological therapy.

This has several potential implications for practice in primary care: first of all, practitioners have little to go on when making decisions of the kinds of clients they work with (Cooper, 2003) in the face of other available modalities with more specified ranges of application such as CBT (Hawton, Salkovskis, Kirk, & Clark, 1989; Stiles, Barkham,

Twigg, & al, 2006) and even psychodynamic therapy (Lemma, Target, & Fonagy, 2011b). Even the more ample existential-phenomenological models of Strasser and Strasser (1997) and Langdridge (2006) offer little on client suitability apart from Strassers' suggestion that clients "who are too dogmatic in outlook, or have a long history of alcohol abuse or drug addiction, for example, would be less suitable" (Strasser & Strasser, 1997, p. 47). An exception is provided by Rayner and Vitali (2015) who explicitly focus on anxiety and depression, reporting decreased symptomatology, but do not report on how this is achieved specifically.

Secondly, the question is raised if and how EP practitioners are able to work in an individualised and phenomenological way in an environment such as primary care that emphasises diagnostic criteria as guideposts to the access, focus and outcome of psychological interventions.

2.3.3.4.Evidence, Measurement & Therapeutic Outcomes

In general the British School is construed as aiming to help clients to understand their own stance within their concerns, find meaning and move towards a more authentic perspective on their life (Cooper, 2003; Spinelli, 2007; van Deurzen, 2012). The usefulness of existential-phenomenological therapy in this process and the success of therapy are mainly discussed at the individual client level, through case-studies or anecdotal accounts. With the exception of Rayner and Vitali (2015), who report outcomes in terms of reduction of symptoms of anxiety and depression as well as overall psychological distress, there is no systematic research into the outcomes or processes of existential-phenomenological therapy (Vos, Cooper, Correia, & Craig, 2015a; Vos, Craig, & Cooper, 2015b). Indeed, measuring therapy has been argued to have a potentially adverse impact on the therapeutic relationship, by 'technologising' the relationship between client and therapist (Cohn, 1997; Spinelli, 2007). On the other hand, Rayner and Vitali (2014) put forward the argument that the use of the CORE system of measures (Barkham, Mellor-Clark, Connell, & Cahill, 2006), specifically the CORE Goal attainment form allows for a flexible and client-centred way of mapping therapy goals while at the same time measuring outcomes in qualitative and quantitative forms.

The lack of empirical underpinnings to British existential-phenomenological therapy appears to be an artefact of a general reluctance of practitioners to engage with academic research (Barnett & Madison, 2012; Cooper, 2004; Mahrer & Boulet, 2004; Rowan, 2001) as it is seen as reductionist. Indeed, within the reviewed literature, the use of systematic methodologies which allow for statements about transferability or validity to be made are far and few between. Neither have the processes that lead to the development of particular ways of working been made transparent, with the exception of a few reflexive statements. This is particularly significant in the light of the current rise of paradigms such as practice-based evidence (Evans, Connell, Barkham, Marshall, & Mellor-Clark, 2003; Henton, 2012) and the growing consensus that clinicians are a valuable source of information about therapeutic practices as they are able to supplement explicit models and theory with accumulated experience, routines of clinical practice, troubleshooting

common clinical problems and pragmatic working models (Addis, Wade, & Hatgis, 1999; Chorpita, 2002).

Notable exceptions to this research aversion are Vos et al's meta-analysis of the effectiveness of existential therapies (but not British existential-phenomenological therapy) (Vos, Craig, & Cooper, 2015b), Wilkes and Milton's (2006) exploration into therapists' experiences of working from an existential-phenomenological perspective, Correia's (2014) exploration into the world-wide distribution of existential therapies, Craig's (2010) study into change agents in existential-phenomenological therapy, as well as Oliveira et al's exploration into significant events within existential-phenomenological therapy (2012).

Honing in on clients' experiences, rather than relying on standardised measures in the way as promoted by existential-phenomenological therapy has the advantage of providing an individualised and personal approach to distress that many clients might find beneficial in primary care (Oliveira et al., 2012) which is often determined by procedures rather than people. However, given the prevalence of the medical perspective of evidence-based practice in primary care, the reluctance towards both the measurement of therapy and the research into therapy on behalf of existential-phenomenological practitioners appears to be an area of potential tension. Particularly, in settings such as primary care where psychometric measures are used and demands are made on practitioners to evidence their work, practitioners might encounter dilemmas in their practice, which might impact on the way in which practitioners might feel they 'stay true' to their beliefs.

Further, the lack of engagement with research as a catalyst for tailoring and evaluating clinical interventions and as forum for clinicians to voice their experiences leaves practitioners at primary care level with little specific or practical guidelines they could follow (Addis et al., 1999; Carroll & Nuro, 2002; Chorpita, 2002; Clarkin, 1998; Westen, 2002). There is a question whether this is experienced as freedom from restriction or alternatively as a lack of direction by practitioners.

2.3.3.5. Technique & Structure

Another dimension emerging from the literature is the question of intervention structure and the integration of therapeutic tools and techniques.

Particularly with the rise of manualised interventions in the wake of programmes such as IAPT the notion of pre-defined intervention structure is increasingly prevalent in the wider psychotherapy literature (Westen, 2002; Wilson, 2007) including the use of therapeutic techniques that show effectiveness in research trials such as diaries or behavioural experimentation in CBT (Hawton et al., 1989) or problem formulation Dynamic Interpersonal Therapy (Lemma, Target, & Fonagy, 2011a). Conversely, existential-phenomenological practitioners tend to be weary of 'once-size-fits-all' thinking (van Deurzen-Smith, 1997), as it is argued to distract from how phenomena authentically arise. Cohn (1997; 2002) adds that structure in the form of therapeutic techniques are a

sign of the anxiety facing uncertainty and a loss of connection with ourselves and the clients.

The approach that most exemplifies this perspective in the literature is that of Strasser and Strasser (1997). Their approach is non-prescriptive, has no underlying fixed session structure apart from a suggested 12 week modular programme. Strasser and Strasser argue that the urgency of the time-limited encounter gives rise to those phenomena that are important to the client (and hence for the therapy) and therefore the resulting structure of each session is lead by the idiosyncratic encounter between therapist and client.

However, there are also a minority of practitioners, who argue that the openness of the phenomenological attitude offers the potential to integrate useful tools and techniques. Langdridge (2006), for example, acknowledges the tension between the therapeutic techniques and the non-directive phenomenological method, but also argues that that the methods of constructivist and narrative approaches, particularly Solution-Focused Therapy “notably the miracle question, deconstructing the problem and exception questions, directly correspond with the methods of phenomenological psychology” (p. 366). He points out the ethical dimension of ignoring methods that are established to be successful, particularly within a brief timeframe. Langdridge is joined by voices such as Nanda and Claessens (Claessens, 2010; Nanda, 2009) who advocate that third-wave CBT practices such as mindfulness to be compatible with existential-phenomenological therapy. Further, Rayner and Vitali’s (2015) use of the concept of collaboration or homework which is more commonly at home in the cognitive traditions. In addition, research shows that technique is not always construed as counterproductive in practice. Wilkes and Milton quote one of their participants as saying:

[...] some people in the existential perspective who say there is no technique, I think that’s rubbish, it’s a mystification, it’s something extreme, I think its lying, of course there’s a technique, phenomenology is a technique (Wilkes & Milton, 2006, p. 76).

From the literature it appears therefore that there is a spectrum on which integration of therapeutic methods in the British School takes place, from un-structured to the integration of concrete techniques. The position that practitioners take on this spectrum might be influenced by the extent to which they perceive existential-phenomenological therapy as an attitude or a therapeutic modality: Craig, for example talks about existential-phenomenological therapy as *démarche*, French for “a manner of walking, the kind of intention and purpose one brings to a particular learning or practice” (Craig, 2012, p. 8). This attitude might facilitate the integration of a range of practices. Others, such as Strasser and Strasser (1997) seem to conceptualise existential-phenomenological therapy as a therapeutic modality alongside other modalities, such as CBT and psychoanalysis and are more concerned with delineation than integration.

For practitioners in the primary care context, the question is equally raised on where to position their practice and how to balance a focus on client concerns with the potential usefulness of therapeutic techniques, especially within the short space of time and an environment that favours operationalised or manualised practices.

2.3.4. Existential Practice in Primary Care: A Faustian Plight

Overall, there is a broad diversity of voices and perspectives taken in the review of the literature, reflecting the diversity of existential-phenomenological therapy within the UK and the wider field of the existential therapies (Cooper, 2015). Despite this and despite the foundational relevance existential therapy has within the profession of counselling psychology, existential therapy traditionally remained outside the territory of primary care. Indeed, the struggle with the public sector, as a marketplace in which evidence-based practice is the currency has been termed a Faustian plight for existentialists (Schneider & du Plock, 2012) and it seems that many existentialists are veritably fear losing their soul were they to dare enter it (Tantam & Kumar, 2009).

However, the literature outlines several important contributions that existential therapy potentially makes to primary care psychological intervention delivery: sensitivity to the contextual nature of therapy, a focus on working within limitations of time, responsiveness to the diverse range of clinical presentations, an individualised and personal approach to distress as well as a sensitivity to clients needs that goes beyond the technical application of therapeutic tools. Moreover, the UK literature also provides some inspiration for practitioners within primary care including several concrete models of therapeutic working. These are supplemented by a number of approaches developed outside of the UK, which adapt to managed care settings.

Yet, as primary care clinicians, existential therapists are likely to practice in the tension between the primacy of the idiosyncrasies of praxis and the common aspects of existential therapy as a psychological intervention (Vos, Cooper, Correia, & Craig, 2015). That is, on the one hand existential therapists have to pursue their critique of essentialist notions of ‘thingifying’ and reducing practice to a set of techniques and universal laws or procedures. On the other hand, they situate themselves within the territory of managed care with its emphasis on homogenisation, standardisation, measurability, risk- and harm management, which is likely to lead to practice dilemmas. From the perspective of this research, the question is raised if and how practitioners are able to manage and negotiate these tensions and dilemmas.

2.4. Negotiating Contexts: A Counselling Psychology Perspective

In the varied topography of professional practice there is a high ground where practitioners can make effective use of research based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society, while in the swamp are the problems of greatest interest (Schön 1983: 42)

As the reviewed literature outlines, practicing existential therapy within a primary care context potentially requires practitioners to negotiate a number of tensions. As Hemsley (2013b) argues, such a negotiation inevitably has an impact both on the level of the therapeutic practice in terms of adaptations that are incorporated into the therapeutic work as well as on the level of the individual practitioner in terms of his/her values. However, as further outlined in previous sections, while existing literature on existential therapy is quite vocal on the theoretical-philosophical aspects, it touches only marginally on the negotiation of professional practice in different settings.

However, the neighbouring field of counselling psychology which, as outlined previously, has a large overlap with existential therapy in terms of values and practices, has developed a relevant body of knowledge (Cooper, 2009; McAteer, 2010; Milton et al., 2002; Moller, 2011; Spinelli, 2003; 2014).

Counselling psychologists have a longer-standing tradition of engaging with medical settings, including primary care (Altaimer, Johnson, & Paulson, 1998; Blair, 2010; Chwalisz, 2003; Konstantinou, 2014; Lamproukou, 2014; Lewis, 2012; Papadomarkaki & Lewis, 2008). For counselling psychologists, the NHS, its underlying medical model philosophy, as well as recent developments such as the introduction of NICE guidelines and IAPT services (Lewis, 2012) take a salient position within their professional horizon. A study by Hensley (2013a), for example finds that the NICE guidelines are increasingly relevant and are experienced as “powerful” and form a “focus of negotiation” (p.95) for counselling psychologists. As the NHS forms a major employer for counselling psychologists (Bellamy, 2006; Lewis & Bor, 2007; Papadopoulos & Bor, 1995) this focus stays relevant to the profession. As such, the literature on counselling psychology helps to further sensitise the current study to the primary care context and sharpen the questions it asks.

As well as being a focus of professional attention the literature identifies the medical model philosophy a central tension in counselling psychology practice. The medical model as the dominant perspective throughout the NHS, is experienced frequently as a source of ambiguity and conflict (Papadomarkaki & Lewis, 2008) as it results in an experience of “the NHS as insensitive, rough and inflexible” (Lamproukou, 2014, p. 115). On a discursive level (Hemsley, 2013a; 2013b), counselling psychologists’ construction of their professional identity produces ideological dilemmas: often counselling psychology as a profession resists the “imposition of the medical model, declaring it to be reductionist in

nature” (Hemsley, 2013, p.91). Further, it is recognised by a few authors that specifically in primary care settings where there are a range of professional relationships and the range of client presentations, these tensions are further complicated (Bellamy & Adams, 2000; Karademas, 2009; Lewis, 2012).

Lamproukou (Lamproukou, 2014) finds that NHS settings pose a number of challenges to counselling psychology practitioners. First of all, the restriction of session numbers poses emotional, ethical and practical difficulties, as it requires practitioners to compromise between their professional opinion of how much time clients need and how much time is available. It also results in practitioners becoming more directive and focussed in their work, which changes the exploratory atmosphere that practitioners value. Secondly, the use of standardised psychometric tests and scales is problematised by counselling psychologists: while they are acknowledged to serve an important function as evidence-bearers, it is also felt to de-humanise distress and often fails to serve the interest of clients. Disagreement is “focused on the intentionality of the tests in relation to the objectification and categorisation of the human nature, but also on the practical aspect of being obliged to use the diagnostic tests” (p.96). Another tension in Lamproukou’s research is the increasing requirement on behalf of practitioners to use standardised treatments, which in their opinion fails to acknowledge the complexity, individuality and uniqueness of clients as well as core humanistic principles, such as the therapeutic relationship. Finally, counselling psychologists experience the kind of language that is used to communicate between professionals including diagnostic labels to form a significant departure from the humanistic position that is more ‘natural’ to counselling psychologists. This last aspect of working in the medical context of the NHS is also mirrored in Larrsson’s (Larsson et al., 2012) research, that finds that the prevalent use of diagnostic categories, specifically schizophrenia in NHS secondary care settings is experienced as standing in tension to counselling psychology’s humanistic value base.

On a personal level, counselling psychologists frequently feel that these tensions lead to negative feelings, isolation, as well as doubts about the validity of counselling psychologists’ role within their practice settings (Papadomarkaki & Lewis, 2008). Lewis (2012) talks about feeling speechless and impotent in the face of the creation of IAPT services and the implementation of NICE guidelines.

On the other hand, while the impact of the medical model in NHS settings is often problematised, counselling psychologists are also keen to engage with the resulting tension and “meet it at the ‘table’ and thus reduce the power dynamic” (Hemsley, 2013a, p. 97). Lamproukou for example, describes a creative process of adjusting and being flexible with both practitioners’ identity and practice in order to narrow the gap between the demands of the NHS and the values of clinicians. Different practitioners develop different strategies to manage challenges and dilemmas, some adapt their preferred way of practicing to find a middle ground between client concerns and therapeutic guidelines, by for example paying attention to their relationship with clients even within a manualised CBT treatment. Another way of negotiating tensions is to promote a dialogue about differences and varying perspectives, by speaking out about counselling psychology values in conversations with other professionals. Thirdly, practitioners at times prioritise patients

needs and their preferred way of practicing over NHS guidelines: this might mean to ignore or circumvent guidelines or using them creatively e.g., using diagnostic labels to ensure clients have gain access to particular services, a stance that has been called value-congruent subversion (House, 2012).

Hemsley (2013a; 2013b) and Mantica (2011) report that the adoption of a pluralistic identity, that is a position that allows to hold several standpoints at the same time and draw on them flexibly, allows practitioners to manage the negotiation that the NICE guidelines pose them. Konstantinou and Mantica (2014; 2011) put forward how working within the medical context might bring forward realisations that professional identity might not be coherent but multi-faceted and at times contradictory. The successful negotiation of these internal conflicts and cognitive dissonances between competing philosophical positions impacts on practice inasmuch as it legitimises certain practices such as cognitive behavioural therapy despite their ostensible alignment with perspectives alien to humanistic-existential value-bases. In her research on counselling psychologists using CBT for example Mantica (2011) finds that practitioners successfully maintain their focus on spontaneous relationships and intersubjective experience while working in a structured and technique-based way.

Therefore, it appears that counselling psychologists within medical settings are often challenged in their values and practices, which leads to adaptation in their therapeutic practice. In addition, the literature points to the relevance of more personal aspects in the process of negotiation practice such as practitioners' sense of the validity of their role. Yet, practitioners manage to successfully negotiate these challenges and they have been argued to form an essential part of professional practice (Hemsley, 2013b). Lamproukou (2014) says:

[...] it is clearer [sic] that although the participants disagree with the mentality of the medical model, and experience different tensions [...], they are still able to hold on to their values while working in the NHS (p.118).

Overall, given the overlap between the values of counselling psychology and existential therapy and in the light of previously discussed literature, the tensions that counselling psychologists face in their practice in the NHS appear to be relevant to existential therapy: exploring the literature it becomes apparent that the *Faustian Plight* of engaging the tensions between managed care and individual clinical autonomy are not limited to the field of existential therapy, but rather present equally within the wider field of applied psychology: it has even been argued that the emergence of counselling psychology particularly can be seen as a response to this debate (James, 2013). Importantly, the way in which counselling psychologist successfully negotiate the difficulties they face might given an indication as to the likely success of existential practitioners, too.

At the same time and in the light of the historical reluctance with which particularly existential practitioners have approached NHS settings, the question is raised to what extent the overlap between counselling psychology and existential therapy translates in actual practice and to what extent they are transferable to the primary care setting specifically.

2.5. Negotiating Professional Practice and Learning

The reviewed literature in both the fields of existential therapy as well as counselling psychology suggests that working in primary care requires professionals to re-negotiate their values, identities and practices. This is frequently framed as a process of learning, development and identity formation (Lamproukou, 2014; Mantica, 2011; Mrdjenovich & Moore, 2004; Papadomarkaki & Lewis, 2008). Given that almost forty percent of counselling psychology placements take place in the NHS (Ramsey-Wade, 2014), including fifteen percent in primary care, it is likely that for many practitioners this process commences during training. While this percentage might be lower for existential practitioners, it might still be important to consider how the process of professional practice negotiation in medical-model settings might be linked to the training and professional development of practitioners; if only to be able to better distinguish between processes of practice negotiation specific to existential therapy and other non-specific processes. In order to take this into account, the literature on training and practitioner development has been reviewed.

In general, authors make a strong link between the way in which practitioners approach practice dilemmas in their work context and their professional and personal development (Lave & Wenger, 1991). Donald Super for example, one of the early pioneers in the area of professional development, developed a life-stage theory: it poses that development for practitioners in different professions fundamentally includes the negotiation of internal and external dimensions of both the professional and personal self (Super, 1980). Holland (1997) argues that professionals search for work environments that provide congruence between their self-perceptions and personality characteristics on one hand, and characteristics of the work environment on the other hand. It emerges therefore as a developmental task for novice professionals and experienced professionals alike develop a match between self and context, or explore alternative versions of their professional identity should no match emerge naturally. While there is little concrete literature thematising such issues in the field of counselling psychology (Cross & Watts, 2002; Gazzola, De Stefano, Audet, & Theriault, 2011; Konstantinou, 2014; Ramsey-Wade, 2014; Rizq, 2006) and no literature in the field of existential therapy, literature exists in the field of counselling and psychotherapy: Ronnestad and Skovholt (2013) argue on the basis of ample empirical material that the process of matching the professional self with the work context involves a reflective engagement and evaluation of therapists' values, their interests and preferences and most importantly their theoretical and philosophical orientation. This often includes the management and negotiation of misalignments of these (Gazzola et al., 2011).

As Ronnestad and Skovholt (2013) further argue, an important aspect of practitioner development is grounded in the extent of their professional experience: as a result, they developed a framework for the development of practitioners from novice student, advanced student, novice professional to experienced professional and senior professional. Further, drawing on Kurt Lewin's concept of 'life space' and Edmund

Husserl's concept of the 'life world' (p.160), Ronnestad and Skovholt posit a relationship between contextual aspects of professional practice and phases of practitioner/practice development.

While novice and partly also advanced student phases are characterised by anxiety and bewilderment (but also excitement) in the face of their complex professional tasks these are slowly replaced over time with increasing professional competence and feeling more comfortable in their professional roles. At the same time, early career practitioners actively look for structured sources of professional guidance such as supervision, instructions and therapeutic guidelines as well as role models from senior practitioners. Rizq (2006) suggests with reference to trainee counselling psychologists, that these process of contextual learning and development, require firstly the toleration of ambiguity and uncertainty and secondly require practitioners to move dynamically between theoretical value-based perspectives and actual practice both on a subjective-internal and objective-external level without getting stuck on either aspect. Ronnestad and Skovholt (2013) suggest that practitioners in earlier stages of learning therefore might become more rigid in the application of theory and in the relation to their clients, while with increasing experience and levels of confidence, practitioners then are able to become more natural and flexible again.

Particularly, novice professionals such as recently graduated therapists within the first five years after training are engaged in building a professional identity within a work context. Ronnestad and Skovholt (Ibid) argue that this identification process can be both hindered and intensified in professional settings where a culture is prevalent that does not match the recently qualified practitioner. These findings are corroborated by Chwalisz (2003). A tension between identifying with the work setting on one hand and the professional background on the other hand might ensue that facilitates reflection on the professional identity. The empirical evidence that Ronnestad and Skovholt (2013) put forward suggests that particularly in environments where a heterogeneous client group with a wide array of presenting concerns is prevalent which the setting of the current research certainly presents, practitioners might experience disillusionment with the particular method or theoretical background their training based predominantly based on. This may result in feeling lost in their work environment and result in therapists re-assessing and critiquing the working models they use. This development is characterised by cycles of self-doubt, anxiety, dejection but subsequent exploration, hope and enthusiasm.

At this point, novice therapists often realise the important impact that the context in which they work has on the way they provide therapy and that general principles such as those they might have learned throughout their training do not hold. Ronnestad and Skovholt point out that:

Generally, the individual at the Novice Professional phase realizes that context-free theory is inadequate. There is an increasing recognition that theory alone does not provide an adequate guide, a disillusionment often relates to realising the limits of context-free theory" (p.87).

This process of negotiating, establishing and developing professional identity continues into the experienced professional phase. Particularly for experienced practitioners,

development is grounded in the experience that therapy in general and their own practice in particular is useful for many if not most clients. Therefore the professional negotiation within the practice context has a certain degree of independence from grappling with the questions of whether therapy is helpful but rather is concerned with adapting practitioners' established practice to the particular context. At the same time, experienced professionals become more flexible in the approaches and techniques they use in their professional work. Ronnestad and Skovholt suggests that there is a shift towards the importance of personal experiences such as having children and family, while the fit with the work context continues to be important, even inasmuch as its impact on burnout and disillusionment with the wider context of the profession such as the social and political context.

Overall, there is a lack of literature on the professional development of existential practitioners and counselling psychologists within primary care. However, the existing literature on the professional development of counsellors and psychotherapists suggests that practitioners engage differently with their context depending on the length of their professional experience. Particularly in the light of the fact that many practitioners are likely to be first exposed to the process of negotiating their practice within primary care during their training, it might be important for the current research to take practitioner development into account.

2.6. A reflective Note on the Process of Reviewing the Literature

The process of reviewing the literature has been a major catalyst for my perspective on this research. The act of reading and sifting through hundreds of articles, books and notes directed my awareness to the fact that I had started the literature review with a number of assumptions about the quantity and quality of literature I might find and the nature of existential (-phenomenological) practice in general. The reality of the breadth of the different incarnations that existential practices take outside the traditional realm of what I came to see as British existentialism, especially the approach that other practitioners took to integrating and adapting existential therapy, initially overwhelmed then fascinated me.

On a personal and professional level, I came to see my own training and way of working as a very particular form of practice. This in turn fell on (at the time still unidentified) fertile ground as it helped to identify a way for me to fit within the pluralistic philosophy of counselling psychology and to develop my practice (both clinical and academic) in a more integrative way.

On the level of this research project, this newfound perspective helped me to loosen my firm grip of what I wanted this research to become: from being interested in defining and circumscribing existential therapy in primary care, I became more interested in the types of processes that enable or inhibit adaptation of practice and the ways in which practitioners take part in this.

Admittedly, it has been difficult at times to bracket the desire to share this new perspective within the research process. Particularly, when devising the interview schedule and when interviewing practitioners it has been challenging not to impose my own newfound understanding onto the participants of this research, by either implying my own understanding in the kinds of questions I asked or by assuming that others might equally experience their form of practice as limiting in the way I realised I experienced my own. However, at the same time my perspective supported my own independence, which allowed me to listen to participants, ask questions and make analytical decision from a broader perspective than that of an 'insider practitioner'. This turned out to be especially important when moving from description to interpretation in the analytic process.

2.7. Summary

As outlined in the introduction to this chapter, the review of the literature aims to sensitise both, the research and the researcher to the research area, ground the rationale made for this research within the existing bodies of knowledge, and open up possible lines of enquiry to develop a research question. The literature on primary care, existential therapy, counselling psychology practice in managed care settings and the literature on professional development was therefore critically discussed.

Overall, primary care's positioning within the UK public health system results in a number of challenges for the delivery of psychological interventions, most importantly a broad and diverse patient population. The current service provision does not always live up to these challenges. Therefore researching interventions that might be able to expand the current service provision forms a valuable contribution, in line with the central agenda of IAPT, primary care's largest programme.

Existential-phenomenological approaches to therapeutic working form a foundational practice within counselling psychology and have grown to be a relatively minor, yet important force in the realm of the psychotherapies. However, existential therapy is not officially espoused by the NHS at the level of primary care. Yet, as the existing literature outlines, existential therapy presents a potentially valuable contribution in this area, as it shows some potential to address some of its challenges. Indeed, in reality there are already existential-phenomenologically trained professionals working in primary care.

At the same time, the medical philosophy and the managed care approach prevalent in many aspects of primary care makes certain demands on clinicians, especially in terms of managing their autonomy. Therefore, working in an existential-phenomenologically informed way within the context of the primary care setting potentially involves a complex negotiation of different value sets and the adaptation of practice, which might present new territory for existential therapy. The literature raises questions as to how this might be accomplished on the level of practitioners.

However, the literature on the wider field practice of counselling psychology, certainly points to a number of ways in which practitioners engage with the negotiation of humanistic-existential values in medical model settings. Importantly, as the reviewed

literature outlines, counselling psychologists appear to be able to preserve their professional identity while practicing in managed care, which further supports the relevance of existential therapy to primary care.

Finally, given that many practitioners might first come into contact with primary care as practice setting during their training, the literature on the professional development of practitioners was reviewed. It emerged that the way in which practice is negotiated in practice settings might be linked to the extent of practitioners' professional experience, which provides a further aspect to which this research needs to be sensitive.

3. AIMS & OBJECTIVES

Existential practitioners, on the whole, tend to reject systems and schools, preferring freedom and individuality [...] Efforts to summarise and systematise such an approach are inevitably counterproductive and, because of this, the profile of the approach can never be raised without damaging its integrity. To know that this is the case has lead many existential therapists to remain silent about their convictions. I believe that such silence rests on the false premise that one should only speak in truth. It seems to me preferable to accept that any formulations one makes are necessarily flawed. I accept the limitations of my attempts to capture some of the intensity and vibrancy of the existential way of looking at things but I want to at least try and speak up about it (van Deurzen-Smith, 2006, p. 3).

As the previous chapters outline, practicing in an existential-phenomenologically informed way within the context of primary care is both, a potentially valuable but also a complex and under-researched professional task.

Therefore, the current research aims to enquire into the experience of practitioners working in an existential-phenomenologically informed way in primary care. It sets out to answer the following question:

How do existential-phenomenologically oriented practitioners negotiate their professional practice within the current context of primary care in the UK?

Specifically, it aims to outline the kinds of tensions and practice dilemmas that they encounter in this context and to elucidate how practitioners manage and negotiate these.

In order to accomplish these aims and provide an answer to the research question, the current study explores qualitatively the perspective of novice and experienced clinicians working in primary care providing existential therapy to clients. Themes and perspectives common to existential therapy will be analysed and validated. Thereby the distinctions between specific and non-specific aspects of existential therapy at primary care level are drawn out and sharpened.

While this study cannot in and of itself provide evidence of the effectiveness or efficacy of existential therapy in primary care and does not aim to gather the kind of data that could argue for this, the findings from this study could provide an indication of whether this is a research trajectory worth pursuing and could lay a foundation for such a project.

4. DESIGN & METHODOLOGY

In the varied topography of professional practice there is a high ground where practitioners can make effective use of research based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society, while in the swamp are the problems of greatest interest (Schön 1983 p.42)

4.1. Contextualising the Present Project

Denzin and Lincoln (1994) suggest to see research as a *bricolage*; a pieced together solution to a specific problem in a concrete situation. Therefore it appears important to outline the methodology and method through the lens of which the research question is approached and to reflectively contextualise the research (Willig, 2008).

The first part of this chapter has two main foci: it firstly discusses the relationship between the epistemological assumption of the research project and those of its subject and how they impact on research questions and shape the research process. Secondly, it makes transparent the researcher's position and dynamic interaction with the process of the research. This is followed by an outline of the methodology underlying this research, including the decisions that lead to the choice of methodology, the role of the researcher within the methodology and the procedural steps followed. The quality criteria that allow readers to evaluate the validity and trustworthiness of this project are also established. Finally, potential ethical issues and the ways in which they are taken into account in the research design are considered.

The overall aim of this chapter is make transparent the decisions that lead to the method used as to allow the reader to come to his/her own conclusions about the validity and transferability of its findings.

4.1.1. Epistemology

As counselling psychology research (Woolfe et al., 2010) and as research that is based on my personal desire to understand more about existential therapy, the present research is based on an ontological position that moves beyond the uncritical relationship between knowledge and reality. It puts forward an 'epistemology of practice' (Polanyi, 1964; Schön, 1995) and a 'psychology of practice' (O'Hara, 2012) championing the values of counselling psychology (Woolfe et al., 2010). This position is principally developed on the basis of the writings of Michael Polanyi and Donald Schön and includes social constructionist and pragmatist perspectives. It is argued that this perspective is congruent

with the existential position (Spinelli, 2001) which allows it to be sensitive to the nuances of existential therapy.

On a fundamental level, the current research is concerned with exploring the experiences of practitioners and systematise from these experiences a body of knowledge that describes the phenomena of existential therapy within primary care. This focus gives rise to three fundamental questions:

- 1) the question of the relationship between experience and knowledge,
- 2) the question of the validity of knowledge claims on the basis of experience and
- 3) the question of how to enquire into such experience-based-knowledge.

In the following, these questions are addressed in turn.

The Relationship Between Experience & Knowledge: Indwelling & Worldmaking

Polanyi (1964), like existentialists such as Merleau-Ponty (1962), put forward the notion that theory (and knowledge) can only be constructed on the basis of (albeit implicit) *a priori* knowledge that is, embodied experience. In order to be able to attend to something in the world we are relying on that which is already an aspect of the self. Michael Polanyi suggests that knowing requires inhabiting that which we know or ‘indwelling’. Merleau-Ponty says:

All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view, or from some experience of the world without which the symbols of science would be meaningless (Merleau-Ponty, 1962 p.ix).

An epistemology of practice proposes then, that in professional working practice, knowing is of experiential nature rather than intellectual, cognitive or theoretical. Knowledge, therefore is based on lived experience, in line with the values of counselling psychology that challenge version of the detached psychologist, the perspective of a value-free enquiry (Rafalin, 2010; Strawbridge & Woolfe, 2003). It is therefore imperative for the creation of this kind of knowledge to start the inquiry from the knower, that is professionals experienced in practicing existential therapy.

At the same time, the epistemological position underlying this research argues that such knowledge based on indwelling does not form in isolation. Indeed, pragmatism and more recent developments in (social) constructionism go beyond Polanyi’s focus on the realm of the personal (Kinsella, 2006; Thorpe & Holt, 2007): pragmatism (Butt, 2003) argues that knowledge is constructed in relation to others and the world. Equally, social constructionism (Burr, 1995) maintains that different bodies of knowledge are co-constructed and negotiated through descriptions and categories depending on the context. Schön adopts the term ‘worldmaking’ from Goodman (Kinsella, 2006; Schön, 1992) to describe the process by which knowledge and therefore reality is built.

A constructionist view of a profession leads us to see its practitioners as worldmakers whose armamentarium gives them frames with which to envisage coherence and tools with which to impose their images on situations of their practice (Schön, 1987, p. 218).

In order to establish knowledge, the process of ‘worldmaking’ has to form part of the enquiry. Concretely, the present research is therefore concerned with interrogating the process of negotiation of praxis of professionals including their personal, professional and contextual position and including the primary care environment where their practice takes place.

Validity of Knowledge Claims Based on Practice

The present research follows Schön in adopting a constructivist stance that posits knowledges rather than knowledge: the same phenomena can be described in different ways giving rise to different understandings. This does not however, as Schön contends, render truth completely relative (Argyris & Schön, 1995; Schön, 1992). In the context of professional practice, including psychology and psychotherapy, particular constructions of knowledge and evidence are more convincing, aesthetically pleasing or useful while it is acknowledged that more than one coherent version is possible. This view is shared by a number of influential constructivist psychologists such as George Kelly and Jean Piaget (Kinsella, 2006) who focus on the pragmatic value of knowledge rather than its ultimate truth. Indeed, pragmatism argues that the question of reality as posed in traditional scientific realism ultimately presents a red herring as we have no way of knowing how far from it we are and therefore it is irrelevant (Cherryholmes, 1992). The position of this research places less concern on questions about the nature of reality and truth but rather how knowledge is constructed in practice. Further, the extent to which this knowledge is useful for the development of further practice is given importance. Hence, while the contextual nature of knowledge is acknowledged, an epistemology of practice also aims to produce knowledge that is transferable beyond the idiosyncratic context. Thereby, it expands the existential-phenomenological focus on unique knowledge-as-lived (Spinelli, 2003).

However, therefore it is paramount for the current research to be transparent about the ways through which particular knowledge claims are arrived at, so that the reader has the opportunity to evaluate their applicability and usefulness in his/her particular context.

Enquiring into Practice-Based Knowledge: from Knowing to Knowledge

In order to create valid, practice-based knowledge from experience, the current research follows the paradigm set out by Polanyi and Schön (Polanyi, 1964; Schön, 1995). Both draw a fundamental distinction between tacit and explicit knowledge. Explicit knowledge is knowledge that is codified or structured in a formal and systematic way and therefore it can be expressed in writing or other forms of knowledge sharing. Tacit knowledge on the other hand is the knowledge of ‘how-to’: we can recognise a particular face within millions of faces, yet we do not seem to have a theory how we can accomplish this other

than an inferred one. Our beliefs, values and ideas are expressed in the tacit knowledge. Tacit knowledge precedes explicit knowledge, a view that also follows the existential credo of ‘existence precedes essence’ (Sartre, 1969). Psychological research based on an epistemology of practice therefore aims to make implicit theories-in-use explicit.

The manner by which this is achieved is through reflection. As Schön points out, reflection forms a central tool for transforming implicit knowledge into explicit knowledge. The importance in reflection lies in the opportunity to become aware and be in a position to question tacit theories, expectations and ingrained ways of working and therefore allows practitioners to engage with their own practice in a more critical way (Kinsella, 2010). This can happen in the moment (reflection-in-action) or subsequently (reflection-on-action) however, all reflection forms part of construction professional knowledge. This calls for an inquiry that provides practitioners with a space to reflect on the details and nuances of their experiences to construct and articulate tacit and explicit aspects of their work.

When practitioners respond to the indeterminate zones of practice by holding a reflective conversation with the materials of their situations, they remake a part of their practice world and thereby reveal the usually tacit processes of worldmaking that underlie all of their practice. (Schön, 1987, p. 36).

It makes therefore sense to conceptualise the project of enquiring into therapists’ knowledge of their practice in terms of a reflective conversation or dialogue. Dialogue has been proposed from several different theoretical perspectives such as social-constructionism (Burr, 1995; Mulkay, 1985) and research methodologies such as collaborative enquiry (Bray, Lee, Smith, & Yorks, 2012), phenomenology (Finlay, 2009) and Grounded Theory (Bowen, 2006; Urquhart, 2012) as a device to take account of people as reflexive, social and mentalising beings, rather than mere ‘research-subjects’.

Therefore, on the level of the research a dialogue takes place between the researcher and the practitioner which Schön calls collaborative reflection. The research setting provides practitioners/research participants with a backdrop on the basis of which they can articulate their version of practice in the form of a dialogue. This might include responding to and expanding on the research themes provided by the researcher, challenging them and bringing new themes to the research. As a result, the present research aims to create a reflective space for existential practitioners to create explicit knowledge from tacit knowledge in dialogue with the researcher. In line with counselling psychology principles, thereby the present research aspires to empower the participants through reflection-in-action (Schön, 1995).

4.2. Personal Reflexivity

It appears that if I wish to become a scientist, the first step is to immerse myself in the phenomena of the particular field in which I have developed an interest. The more complete the immersion, the longer it lasts, the more I love and prize the whole field, the more open I am to all the subtleties of my experiencing, the more likely I am to discover new knowledge. This means a tolerance for ambiguity and contradiction, a resistance to the need for closure, the valuing of unbridled curiosity. It means soaking up experience like a sponge, so that it is taken in all its complexity..." (Carl Rogers, in Kirschenbaum & Henderson, 1996, p. 269)

As a consequence of the epistemological position chosen for this research, it is important to take into consideration that not only research participants are reflective, but also the researcher. This places the researcher within the research, rather than outside of it in the tradition of the objective scientists (Willig, 2008). Consequently, Guba and Lincoln (2005) talk about different selves that researchers bring to the research: the self that is historically, socially and personally developed and those situationally created selves which come into play when the researcher interacts with the research and the participants. Therefore, it is important to be aware, to be reflexive about the resulting interaction of voices and the product of research which is the outcome of this interaction. Personal reflexivity (Willig, 2008) needs to be integrated into the research process. This engages readers not only on a personal level but also puts them in a position where they can evaluate the research and its findings for themselves, making the researcher and the research accountable.

Early proponents of reflexive research and those closer to quantifiable research (Cutcliffe, 2003) suggests that reflexivity makes 'bracketing' possible; the process of withholding some of the preconceptions in order to allow for neutrality within the research process. More recently, qualitative research paradigms are increasingly taking an 'inclusive' stance (Finlay, 2008; Shaw, 2010; Willig, 2008) arguing that *a priori* knowledge can make a valuable contribution to research as long as the research process is reflexive and enabled to critically evaluate such contributions: as Heidegger (2006) points out, when we encounter things (Dinge), we will inevitably have a perspective on things that is impossible and even more importantly fruitless to bracket. Because only through the perspective we take on things they become meaningful to us (West, 2011). However, we can strive to be aware of our perspective and the preconceptions.

One of the fundamental ways in which this is realised is a high level of self-consciousness in order to draw out the manner in which presumptions, assumptions, world-views and biases shape the emerging phenomena (Spinelli, 2001). Particularly counselling psychology research aims to make use of the skills necessary for supporting clients towards greater self-awareness and incorporate these self-reflexive attitude as part of the research narrative (West, 2011). This might be even more relevant for those counselling psychologists like myself, who draw in their identity from an existential perspective which poses the fundamental importance of making use of myself in my professional practice (Spinelli, 2001; van Deurzen, 2012).

Yet, even the most comprehensive reflective description cannot fully account for the creativity, intuition and insight, the “magic” (May, 1994) of qualitative research. Following Cutcliffe, I argue in favour of methodological rigour while at the same time subscribing to the notion that an undue emphasis on reflexivity, that is an attempt to account for every conclusion and every argument put forward in terms of the underlying reflexive process might indeed stifle the creative process that leads from the initial research question to the final product (2003).

While I acknowledge the fundamental importance of my own reflective stance, the emphasis in this research project is more on the perspective that practitioners take towards their work. Concretely, I wrote reflective research memos (Charmaz, 2006) throughout the research and analysis process, which provide accountability but are also deliberately structurally delineated from other research processes in the narrative of this project in order to emphasis the focus of this research. Most chapters and subsections have separate reflexivity accounts which relate my own reflections on important choice points within this project (Shaw, 2010).

4.3. Methodology

Based on the chosen epistemological position at the intersection of pragmatism, constructivism and social constructionism and based on the outlined ‘insider’ perspective on my reflective involvement in this enquiry, initially Thematic Analysis was chosen as research methodology. However, after conducting and evaluating the pilot study this was later changed to Grounded Theory. The following section sets out the rationale for this and subsequently discusses the application of Grounded Theory in the context of this research.

4.3.1. Choice of Methodology

As already outlined in the introduction, the process of designing this research moved me away from quantitative research as the lack of academic literature and existing research on the researched topic warrants a more exploratory and open-ended perspective (Willig, 2008). Qualitative research might help to establish focussed lines of enquiry and a specific set of questions, which future quantitative research might be able to pick up fruitfully.

Within the field of qualitative research methodologies, I then considered a range of methodologies that are congruent with the epistemology of practice underpinning this research. Concretely, I considered methodologies that are compatible with the notion of knowledge as constructed in the social and professional context while at the same time considering its pragmatic use and fit with the reality of practice. This includes the notion of seeing human beings as active agents and world-makers who reflectively construct explicit knowledge from implicit experience. Further, the intended audience as well as practical implications, such as sample characteristics and depth of analysis (West, 2014) impacted on my decision making process. Therefore, I considered discourse analysis,

collaborative enquiries, phenomenological methods, thematic analysis and grounded theory as possible research methodologies.

Methodologies focusing on discourse such as Discourse Analysis, Conversation Analysis, Discursive Psychology (Potter, 1996; 2003) were excluded at an early stage. Although language and discursive strategies obviously plays an important role in the negotiation of existential therapy, it is not the intention of this research to focus on how this is accomplished in detail on a discursive level or on the level of the narrative structure. In this respect, the epistemology of this research tends more towards a pragmatist view and away from a hard stance on social constructionism, as it is interested in the kinds of clinical implications that follow negotiating therapeutic practice in a particular way. Further, while my own research experience (Koebbel, 2008) sensitised me to utility of discursive approaches, it was important to me to recognise the personhood and inner experiences of individual practitioners, which is epistemologically de-emphasised in discursive approaches.

Collaborative approaches from the family of Collaborative Enquiry (Bray et al., 2012) and Action Research (Whitehead & McNiff, 2006) were also considered but due to the dispersed nature of the sample, these approaches were dropped: collaborative approaches require participants to agree on regular meetings and are usually driven by the common motivation to investigate a particular phenomenon rather than being initiated by the researcher for the sole purpose of one research project.

Descriptive phenomenological approaches' (Langdrige, 2007; Moustakas, 1994; Willig, 2008) separate description and interpretation of reality and attempt to minimise the interpretation within the research encounter. They require the researcher to bracket pre-existing knowledge in order bring out the phenomenon as it is experienced by the research participant rather than the phenomenon as a material reality. As previously outlined, this emphasis runs counter to the epistemological position of this research, which explicitly includes pre-conceptions and interpretation, albeit in a reflective way.

As a result, Interpretative Phenomenological Analysis (IPA), Thematic Analysis (TA) (Boyatzis, 1998; Braun & Clarke, 2006) and Grounded Theory (Glaser & Strauss, 2012; Urquhart, 2012) were considered in detail on account of their epistemological congruence, their focus on enquiring into experience and their focus of searching for themes across participants' accounts. There exist different version of Grounded Theory, that are located within different, albeit often overlapping epistemological positions. Glaser and Strauss (2012) but also Strauss and Corbin (2007) locate themselves more within a positivist or realist position (despite some shifts in their positioning over time). Therefore they place greater emphasis on deduction, suggesting that hypothesis should be generated from initial analyses of the data, which drive analysis of further data to 'test' them. Charmaz (2005; 2006) on the other hand adopts a more post-modern, constructionist perspective. According this perspective, theories are not discovered within the data by an objective researcher, but rather constructed by a reflective researcher on the basis reflective research participants in interaction. This version of Grounded Theory fits better with the epistemology of this research. It also is more applicable within a poorly

researched field such as the current research where open exploration takes precedence over *a priori* assumptions and hypothesis.

It has been variously argued within the literature (Banister, Bunn, Burman, & Daniels, 2011; Patton, 1990; Smith, 2008) that for small samples and on the basis of an epistemology which acknowledges the constructed nature of reality without moving towards a hard stance on social constructionism, Interpretative Phenomenological Analysis, Thematic Analysis and Grounded Theory are very similar in practice.

IPA procedures aim to stay close to the data, because codes and themes are developed on each data item and they focus on the unique characteristics of each individual participant, because coding and theme development takes place for each data item in turn. They are particularly appropriate to enquire into the ‘texture’ and ‘tone’ of participants’ individual lived-experiences (Shinebourne, 2011a). However, it has also been questioned whether the last step of IPA, the drawing together of themes into an overarching table receives less interpretative attention and therefore themes across the entire data are less robust (Willig, 2008). The aim of the present research is to develop an outline of the kinds of negotiations of practice that take place across participants and within the social context of primary care rather than on the level of the individual participant. Therefore, I considered TA and GT more appropriate as they specifically help the researcher to identify patterns across the entire data set and can be used to explore the relationships between themes and the functions of themes (Braun & Clarke, 2006; Charmaz, 2006). This also serves the purpose to create findings that establish more robust theoretical transferability and therefore contribute to the knowledge base of the community of existential practitioners. Further, IPA is usually used with a more homogenous sample, whereas the range of perspectives among the population for this study is potentially broader, as they come from counselling psychology, psychotherapy and various different stages of professional development. Both TA and GT are able to accommodate less homogenous samples.

Given the similarity between TA and GT, especially the social constructionist version of grounded theory (Charmaz, 2006), from the perspective of a novice researcher it was ultimately the epistemological flexibility and accessibility that lead to my decision to use TA. Given my epistemological basis in a number of authors not traditionally situated within social constructionism such as Polanyi and Schön (Polanyi, 1966; Schön, 1995) it was initially thought that being epistemologically flexible allowed for a closer matching between the design and methods of this research as well as enabling an integration both at the level of the content of participants accounts but also at the level of the meaning that participants ascribe to their accounts. Further, particularly for the field of psychology (Braun & Clarke, 2006), TA appeared more accessible than the more diverse and historically complex grounded theory.

4.3.1.1. Pilot Study

In order to trial the research design, a pilot study was designed and carried out. Specifically, the pilot study was designed to trial the methodology, data collection, including the interview schedule, and the data analysis.

The results of the analysis of the pilot data point towards some of the major categories which were developed later on the basis of the entire data: the tension between existential-phenomenological practice and the primary care environment was visible as well as the process of grappling with this tension. Particularly, the limitations of time stood out as an example of this process. Other themes such as the delineation of existential-phenomenological practice from other therapies, the structure of the therapeutic sessions and the types of clients seen in primary care which would later form more minor elements of larger categories were also present.

However, as my understanding of the research methodology grew through practical application as well as through the ongoing supervision process and feedback from the doctoral programme team, I questioned both the rigour with which the research methodology was grounded in the research design and the research design itself.

Particularly, and counter to my initial perspective, 'Thematic Analysis' flexibility in terms of its epistemological and methodological basis (Braun & Clarke, 2006) resulted in a distraction away from the aims of the research towards more methodological aspects which I felt were counter-productive.

Further, the theoretical integration of the initially proposed two parts of this study (individual interviews followed by a feedback process into several focus groups) raised questions: it emerged that there was a lack of clarity as to the function of the second part of the research both in terms of its validity purpose and also the intention to use focus groups to sharpen similarities and differences between existential therapy in primary care and existential therapy in other settings. The way Thematic Analysis is most frequently used (Boyatzis, 1998; Braun & Clarke, 2006; Wallace, 2011; Willig, 2008) includes either interviews or focus groups, but not combining both. A further literature search did not result in any examples of similar designs, which might have helped to clarify the design.

Therefore, I decided to reconsider Grounded Theory, particularly the social constructionist version put forward by Charmaz (2005, 2006, 2008) as it offers a theoretically grounded and established way of building knowledge on the basis of an iterative process of data collection with a variety of sources.

Counter to my initial understanding of Grounded Theory, its roots in pragmatism (Glaser & Strauss, 2012), that is how human beings create structure through engaging in processes and problem solving practices fits well with the epistemological perspective of this research, especially with Schön and Polanyi's focus on the construction of professional practice. Particularly, Charmaz' version (Charmaz, 2006) honours this tradition, while at the same time emphasising the socially and contextually constructed nature of knowledge

through reflective dialogue. Indeed, Grounded Theory has been argued to provide a good methodological and epistemological basis for researching existential therapy (Lantz, 2004).

While changing the research methodology presents a significant change to the design of studies, I felt that in this particular case, my existing research design, already followed important Grounded theory strategies, despite having been developed on the basis of Thematic Analysis: first of all, the iterative data collection design, namely individual interviews and re-interviewing participants is an established strategy in Grounded Theory and indeed forms part of the ‘good practice’ of Grounded Theory (Charmaz, 2006). Additionally, Grounded Theory methodology allowed me to expand the iterative nature of the research process to include the ongoing development of the interview schedules thereby providing me with a robust framework to integrate the different parts of this research design. Secondly, the aim of my research to sharpen distinctions between specific and non-specific aspects of existential therapy in primary care benefits from the more structured methods of enhancing the conceptual clarity used within Grounded Theory, such as ongoing code comparison (constant comparative methods), focussed coding and theoretical sampling (Urquhart, 2012). Especially, theoretical sampling within a Grounded Theory framework allows adapting both the participant recruitment process and the interview schedule to the emerging themes and codes which results in a more responsive account. It also results in findings that are more emancipated from my own biases and pre-conceptions, thereby increasing transferability. Thirdly, findings arising from Grounded Theory also have the potential to provide a more systematic and internally coherent theory of existential therapy in primary care which is one of the original aims of this study and which might be of interest to the wider community of psychology with its basis in more traditional scientific enquiries. Grounded Theory also has the potential to provide some explanatory power of the studied phenomena (Charmaz, 2006) through “the generation of theory” (Henwood & Pidgeon 1992, p.6) that exceeds that of Thematic Analysis which is more exploratory and open-ended in nature. Finally, the greater structure and the resulting more bounded approach of Grounded Theory helped me to stimulate my creativity, particularly as a novice researcher.

As a result, subsequently design and methodology were amended to a Grounded Theory approach (with the permission of the programme of studies board) for further data collection and analysis to allow for a better integration of the different parts of the design. This included a re-analysis of the pilot interview data using this methodology.

4.3.1. Introduction to Grounded Theory

The following section provides a brief overview of the version of Grounded Theory employed in this research as well as the ‘spirit’ in which it is approached as a method of enquiry. Further subsections outline the concrete procedural steps taken in more detail.

Grounded Theory, in a constructionist version, is an inductive, data-driven approach, whilst at the same time enabling integration of prior understanding of the research field (Charmaz, 2006). As such, it is appropriate for the use in a context where research,

theoretical literature, but also lived-experience (including my own experience as primary care practitioner) provide some prior themes of potential importance to the phenomena of study.

Grounded theories in the tradition of Charmaz and other post-modern/constructionist authors (i.e. Rennie, 2000; Willig, 2008) are interpretative in nature. Therefore, while definitive knowledge claims can be made from such theories, it is acknowledged that such claims develop in a particular context and that there are other potential voices within the same data (2008; Roulston, 2001).

Grounded Theory facilitates a creative approach to the research inquiry and is not the application of a one-size-fits-all method. Although attempts have been made to provide a formalised protocol of analytic procedure for Grounded Theory (Corbin & Strauss, 2007), my own stance follows authors such as Charmaz (2006), Willig (2008) and Melia (1996) arguing that at the heart of Grounded Theory is the engagement with the relationship between the researcher, the questions he asks of the research and the research enquiry. Charmaz (2006) certainly encourages researchers to develop not only their research questions and research data into an theoretical account but also develop the method for doing so along the way. Equally, Melia warns that the “technical tail is beginning to wag the theoretical dog” (p.376) when ‘technique’ is overemphasised in Grounded Theory.

Therefore, both the design and analytic procedure of this research were kept as open as possible in order to allow for the data and my own engagement with the data to lead the way. Indeed, both the research question as well as the interview schedule changed as a result of the research process: when I started the research I was more interested in a definition of existential practice at primary care level. However as the data collection progressed, my emphasis shifted to those processes of negotiation that take place in order to arrive at a ‘workable’ version of existential practice, as it were these processes that practitioners ascribed importance to. As a result, further literature was reviewed and integrated to develop the theoretical basis of the research and to allow it to be integrated into the wider academic context.

The different elements of the research procedure followed (see Fig. 1) are described in more detail in the following sections, including the role of the researcher, the sampling process, the interviews and subsequent transcription of the data, as well as coding, memo writing, constant comparative analysis and employing a member check.

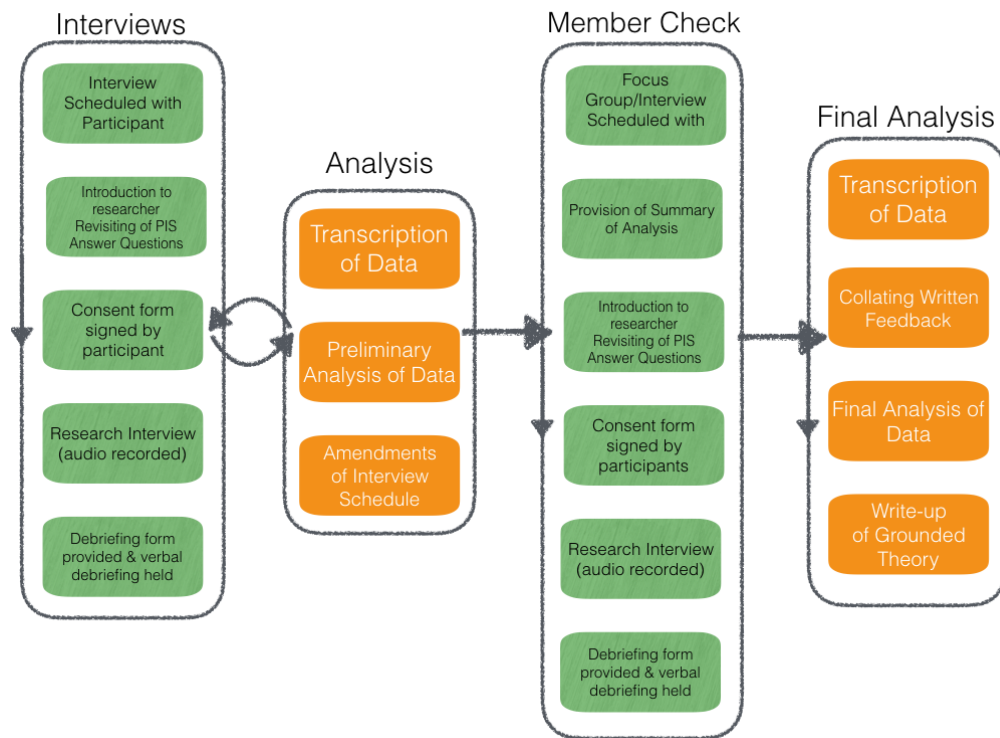


Fig. 1: Overview of the Research Process

4.3.2. Role of the Researcher

As already outlined in more detail within the epistemological position this project takes, my role as the principal researcher was that of an insider/outsider (Bola, 1996; Woollett, 1996): as an existential-phenomenologically informed practitioner with experience of practicing within primary care, I had both personal experience and a stake in the research process. My insider perspective was instrumental in the design and method of the present research (Bowen, 2006) as already outlined.

On the other hand, my role as a researcher in the present project was that of an ‘explorer’ seeking to develop knowledge of a transferable nature, beyond my own experience. I also took on the role of interviewer, seeking to facilitate the conversation with participants and their own reflective dialogue. This includes making sure that the research questions are addressed and explored. I frequently experienced tensions between these positions, which are mostly explored in the remainder of the methodology section alongside other methodological considerations.

The first important dilemma between the position as insider and outsider emerged very early in the development of this research: the impetus to start this research project developed from my own experience of the usefulness of existential practice within primary care and it was important to me to provide evidence of this to others through this research project. At the same time I did not want to impose this assumption un-

reflectedly on this research project. In order to develop my insider position, I engaged with relevant literature before designing the research as well as discussions with other colleagues. While this not general practice within Grounded Theory methodology, and indeed some authors explicitly warn against doing so (Corbin & Strauss, 2007), it is congruent with a constructionist/constructivist epistemology (Charmaz, 2006; Willig, 2008). A ‘blank slate’ approach is not only theoretically and practically impossible but also might run the risk of losing out on relevant knowledge and existing research. As a result of the process of engaging with sources of opinions and knowledge beyond my own experience I then developed research aims and objectives that were more emancipated from the notion of ‘usefulness’ while opening up the potential for this assumption to be tested.

4.3.3. Sampling

Following the exploratory nature of this research, the underlying philosophy of the sampling strategy is comprised of two related strategies: theoretical sampling (Corbin & Strauss, 2007) and snowball sampling (Ridley, 2012): this means that rather than circumscribing the sample *a priori*, sampling was performed iteratively, and the search strategies evolved as more of the data was analysed in order to develop a concise and comprehensive grounded theory.

Advertisement

A mixture of broad advertisement at several universities through advertisement on relevant notice boards and mailing lists, several websites specialising in research (e.g. findparticipants.com), including the Division of Counselling Psychology Facebook website, four different mailing lists (Division of Counselling Psychology, Psychology Postgraduate Affairs Group, BPS Newsletter, Mailing List for Counselling Psychologists in the UK), the DCoP annual conference, and snowball sampling via participants and colleagues and the use of inclusion/exclusion criteria was used in sampling for this research. Potential participants were then given information about the research by way of the participant information sheet (Appendix III) before they were included.

In order to determine the sample characteristics, a number of theoretical and practical aspects have been considered. Sampling decisions were made in the light of the emerging analysis. This means checking the emerging theory against the reality by sampling incidents that may challenge or elaborate its developing claims. Within earlier phases of the development of the grounded theory, sampling was deliberately broad and flexible to be able to capture a wide range of descriptive categories and as to avoid premature closing of research hunches and categories. This meant that participants were sampled for their diversity. Initially, five participants from different backgrounds in terms of training, professional qualification and the types of services they had worked in were sampled to create a sample that covered as many aspects of existential practice as possible. Further into the development of the grounded theory, sampling was used to explore, refine and

saturate developing categories: a further four participants were recruited in order to follow up on emerging leads from the data analysis and to reach a confident level of theoretical saturation. As outlined in more detail in the text below, theoretical saturation for this research was defined as the point in the analysis where no new categories emerged from the data and subcategories no longer change in a significant way.

Inclusion criteria

It was decided to base the inclusion criteria on minimum professional experience rather than formal professional titles or accreditation (e.g. chartership, professional accreditation or academic title). This was in order to account for several characteristics of the professions that recruitment was likely to include: first of all, the training route of one of the two major institutions training existential practitioners in the UK (the New School of Psychotherapy and Counselling) offers access to accreditation for both psychotherapy and counselling psychology through a mostly joint programme with various exit points. Therefore, for example qualified psychotherapists might continue training in counselling psychology without exiting the programme and without formally being awarded a title. Further, some practitioners chose not to be accredited (e.g. with UKCP or BACP), given that the profession of psychotherapy is not regulated (despite efforts to enforce this (Haney, 2012)).

It was anticipated that this sampling strategy might result in a mix of experiences acquired during and after professional training but given the exploratory nature of this research a broad enquiry into different stages of practitioner development was not deemed a limitation but rather an added angle that might provide preliminary understandings that could be explored in further research. At the same time, it is acknowledged that less experienced practitioners might grapple with different aspects of professional practice than more experienced practitioners (Rønnestad & Skovholt, 2013) and this might indeed impact on the collected data. In order to highlight such processes the interview process was sensitised to this and follow-up questions endeavoured to explore the professional processes in relation to experience. In order to support this, the literature review was broadened to expand my own awareness of potential implications further (Bowen, 2006). Indeed, one of the major categories (category 4) of the grounded theory focuses on different levels of professional experience. As with other methodological decisions, the iterative design of this research allowed me to trial this approach. As further outlined in the analysis the inclusion of experience from training placements not only broadened the scope of this project but also resulted in the conclusion that while there is a differing degree with which practitioners grapple with practice as trainees, there appears to be no fundamental difference to more experienced practitioners. Further, the time lapse between the individual interviews and the focus group allowed for a reflection on the development as practitioners and indeed this took place as part of the focus group.

Specifically, the inclusion criteria for participants were:

- at least one year experience in primary care

- holding a professional qualification in counselling, psychotherapy or psychology or alternatively
- being in the final stages of training towards such a qualification
- professional training includes at least 2 years of training in existential practice

Exclusion criteria for participants were:

- less than 150 hours of supervised practice and
- clinicians who do not self-identify as practising in an existential/phenomenological informed manner

Sample size

Determining sample sizes for qualitative projects is a somewhat contentious issue among authors (Guest, Bunce, & Johnson, 2006), and more specifically grounded theorists (Charmaz, 2006) and there is little consensus about numbers. Determining the sample size is further complicated by the entirely undocumented community of practitioners delivering existential practice in primary care and therefore it is difficult to estimate the size or characteristics of the community. In addition, due to existential therapy in primary care being somewhat of a niche, there are practical limitations to sampling.

Sample size recommendations for Grounded Theory are mostly based on the opinion of authors, rather than systematic evidence (Urquhart, 2012; Willig, 2008)}. Where there is evidence, sample numbers as low as 6 to 12 participants seem to result in data saturation (Guest et al., 2006). Importantly, both group homogeneity as well the degree of expertise of participants ('cultural competence') have been argued to play role in increasing data saturation early on (Ibid). From a theoretical position, data saturation should be the criteria determining the sample size (Baker & Edwards, 2012; Corbin & Strauss, 2007), however, this is difficult to predict reliably before the analysis is conducted, and even afterwards data saturation is somewhat difficult to establish, particularly given the constructionist stance that this research takes (Guest et al., 2006).

In line with these considerations, an initial approximation of the sample size was undertaken in order to make a project plan that takes into account the limited resources and time available, given that the present research forms part of a practitioner doctoral programme. It was aimed for a sample size between 8 and 20 participants to be realistically obtained while at the same time being sufficient in terms of data saturation and variability (Guest et al., 2006) even though being located at the lower limit of minimum sample size. Given the shared work environment in primary care, this study can be assumed to form a homogenous group and the cultural competence, i.e., the degree of expertise of participants on the research subject was deemed to be high. Therefore a smaller number of participants could be recruited.

In line with Grounded Theory methodology, the actual sampling was mainly theoretically led by the emerging grounded theory. The actual final number of unique participants was nine. The validity of the Grounded Theory was further increased through the member check: the focus group included five of the original nine participants, which is in line with

recommendations from the research literature (McLafferty, 2004) which lie between three and a maximum of eight participants per focus group. In addition, two further participants from the original group of participants was interviewed individually to contribute to the member check.

Theoretical Saturation

Ideally, with the provision of unlimited time and resources, and in accordance with the versions of Grounded Theory methodology located in a more positivist paradigm, data collection and analysis continues until no new categories can be identified, and until new instances of subcategories have ceased to emerge (Corbin & Strauss, 2007). However, as Willig (2008) argues, “theoretical saturation functions as a goal rather than a reality” (p. 217) both in terms of practicalities and in terms of a post-modern conception of Grounded Theory (Charmaz, 2005): theoretical saturation is a notion that has sparked some controversy (Charmaz, 2005; Dey, 1999) and it is indeed difficult to establish theoretical saturation. Therefore, I have followed the maxim that the notion of theoretical saturation provides a useful concept for engaging with the data and I have intended to put forward a grounded theory that is based on theoretically saturated categories as far as possible.

Indeed, most elements of the major categories ‘The Medicalness of Primary Care’ and ‘Negotiating Practice in Primary Care’, showed near theoretical saturation after five interviews. This initially surprised me and so I continued to explore these categories, but I was confirmed by my growing confidence in my analytical skills that I developed throughout the research process. Equally, only minor amendments were made to the category ‘Impact of Professional Experience’ after the initial five interviews. The category ‘EPP in Primary Care’ was amended beyond the initial five interviews but showed saturation around interview eight.

Of course, the ongoing analysis opened up further avenues of exploration, for example the way in which practitioners integrate other approaches and models into their practice, the way their practice changes with growing experience and the relationship between the identities of psychotherapist and counselling psychologist. However, these were not deemed to constrain the final version of the Grounded Theory and in practice time and resource constraints and the already discussed small community of practitioners necessarily limited the amount of further data gathering I could undertake. Personally, I feel that I was able to strike a good balance between theoretical saturation, the doctoral requirements as set out by my university and the practical aspects of conducting this research.

4.3.4. Interviews

Further to the sampling process, the interviews conducted as part of this research are an integral part of the research; not only as they are the means for data collection, but also because the interviews present a paramount point at which the data is constructed

between the interviewer and the interviewee. As a result, particular attention was paid to developing the interviews and the interview questions.

My own *a priori* knowledge of existential therapy within primary care was instrumental in the process of facilitating the interviews. As Kvale points out:

The interviewer's ability to sense the immediate meaning of an answer, and the horizon of possible meanings that it opens up, is decisive. This, again, requires knowledge of and interest in the research theme and the human interaction of the interview (Kvale & Brinkmann, 2009, p. 134).

Kvale's (Kvale & Brinkmann, 2009) guidance for good interviews was followed to the extent that interviews were aimed to produce spontaneous, rich, specific, and relevant answers from the interviewees. The content and meaning of these were clarified and followed up and I attempted to clarify my own interpretations on the participants' answers throughout the interview with the view to create an interview that is "a self-reliant story that hardly requires additional explanations" (Ibid p.192), thereby contributing to the creation of transparent findings. I aimed to facilitate interviews that were interpreted already throughout the process of interviewing in order to stay as close as possible to the participant's stance and incorporate their reflection-in-action (Schön, 1995). My own professional training with its emphasis on supporting clients to develop their own stance helped me in this. I aimed to create shorter questions in order to allow for the interviewee to expand their own position. Whilst trying to avoid directive or closed questions or interpretations, I adopted a stance of responding to the interviewee. In this way, questions were used to promote a two-way dialogue. In line with the exploratory nature of this research, it was not deemed appropriate to use more structured knowledge elicitation techniques for example task analysis (Hoffman, Shadbolt, Burton, & Klein, 1995).

Interview Schedule

The iterative versions of the interview schedule (see Appendix VI), consist of a brief introduction of the context of the study, six to seven open-ended questions with prompts for further questions to deepen the interviewee's responses and a debriefing at the end of the interview. The interview schedule serves as starting point in order for participants to elaborate further.

The interviews start with broad "grand tour" (Spradley, 1979, p. 85) questions to familiarise participants with the topic, the interview context and more generally to generate a "flow" in the relationship between myself and the interviewee. Subsequently, questions move to more specific aspects e.g., "What do you do each session?" to get more focused accounts, and also to explore particular notions that have arisen from the literature review (Johnson & Weller, 2001), such as potential tensions between interviewees' practices and their context. At the same time, interviewees' cues were followed and if a question was deemed answered from other interview content, it was not asked again.

The initial interview schedule was developed on the basis of my own experience in primary care and the existing literature on existential therapy in line with Grounded

Theory methodology (Charmaz, 2006). While Grounded Theory research is data and participant driven it requires a starting point from which to further amend the enquiry: initially a broad set of questions were generated with the aim to provide a basis for further distilling promising leads. In practice, I incorporated questions that arose for me during the planning phase of this research and from an interview on my experience in primary care that I asked a colleague to conduct with me. This personal view was reflectively balanced with themes that emerged out of the literature review and from conversations with colleagues and my supervisors. From this a strong theme re-emerged: that of a mismatch between the culture of primary care and existential therapy. I used this perspective in the development of the interview schedule. Particularly, the initial interview schedule aimed at drawing out potential dilemmas and clashes emerging from the literature, such as the use of psychometric measures and the measurement of outcomes. At the same time, I was aware that not all of the recruited participants might experience such a mismatch, and therefore the questions needed to be open-ended and allow participants not only to disagree but provide them with an opportunity to put forward their own perspective. Moreover, while the initial interview schedule was elaborated to some detail, in line with the epistemological position of this research, throughout the interviews preference was given to the dialogue between researcher and participants over a rigid interview structure, in order to develop participants' implicit experience into explicit knowledge.

Further interview schedules were based on notions that emerged as a result of earlier interviews. The aim was to gradually develop a comprehensive theory, by closing down saturated or less fertile directions and focussing on promising themes shared across participants.

Personal Reflexivity

The fact that the interview process can be oppressive in addition to being liberating became especially clear to me throughout the early individual interviews: at times I felt that participants found it difficult to relate to a subset of my questions, particularly those that asked participants to discuss their clients in terms of 'client types'. This presented a rupture in our mutual understanding of client-work as I was aiming to establish commonalities between clients for the purpose of a common theory, whereas practitioners' ideological position was often focussed on individual and idiosyncratic processes. In these situations I became aware of the tension between my role as facilitator-explorer and that of a researcher interested in building a 'good' theory and also the position of power I was in to frame participants' contribution to fit my own frame. I was very grateful for my professional training that allowed me to become aware and be reflexive about these processes. Subsequently, I amended the interview schedule and made sure that ruptures in understanding were represented accurately in the research report.

4.3.5. Transcription

As the focus of the grounded theory was at the level of verbal units, interviews were transcribed verbatim. Edwards (1993) suggests that two design principles for transcription systems: firstly, the transcript needs to “preserve the information needed by the researcher in a manner which is true to the nature of the interaction itself” (p.4) and secondly, that transcription formats needs to be practical. As the present research is not concerned with linguistic analysis, nor in-depth analysis of psychological states and emotions that would require an inclusion of linguistic devices, pauses, repetitions, tone of voice, etc., a traditional form of representing the transcribed data has been chosen, similar to the one suggested by Banister (Banister et al., 2011) (see Table 2).

Symbol	Meaning
...	Short pause
[2s]	Pause of 2 seconds
.	Indicates stopping tone of voice
,	Indicates continuing tone of voice
?	Indicates a raising tone of voice and reflects a question
[comment]	Comment inserted by the researcher
[..]	Indicates omission by the researcher, this might be because a full quotation is too long, or because analytically not relevant
Words in italics	Indicates emphasis
“Quotation Marks”	Indicates where participant is giving an example of speech.

Table 2: Transcription System

A citation style for extracts was adopted according to the following format: ‘IntervieweePseudonym, Time (Hour.Minute.Second)’ in order to locate extracts within the particular transcript identified by the pseudonym of the interviewee. Extracts taken from the follow-up focus group or individual interviews are preceded by ‘FG’. When citing extracts from the transcript both the time stamp (referring to the beginning and end of an uninterrupted utterance) and the interviewee pseudonym is given rather than a line number of the transcript: it was felt that this linked participants’ accounts to the original interview and it is made explicit that the analysis is based on a face-to-face encounter rather than on a text whose author is somewhat removed and inaccessible.

4.3.6. Coding

Coding was preceded by firstly familiarising myself with the data, including listening to the audio recording, transcribing interviews (individual and focus group), reading and re-reading them and noting down initial ideas and memos. Initially, each interview was coded

separately. Before moving on to the next interview, I summarised the main features of each interview and looked for dominant accounts, following the memo-writing technique.

In addition to the more broad quality criteria for Grounded Theory discussed in further below, accuracy of the coding, category development and theory development was established following a slightly adapted version of Braun and Clarke's (2006) quality criteria for coding and analysis. Despite being specific to Thematic Analysis, it was deemed that these criteria capture the nature of a post-modern Grounded Theory (see Fig. 2).

Initial coding was carried out line-by-line in order to ground the analysis firmly within the data (Willig, 2008) and to develop descriptive categories at a lower level of abstraction.

The second stage of coding included regrouping of descriptive categories into a more theoretical account across the entire data, rather than just within individual interviews. Rather than being a linear process however, this is done in a hermeneutic fashion (Rennie, 2000) by moving to and from the different parts of the data: earlier text might also be analysed in light of later codes and categories.

Codes and categories were selected in terms of their 'keyness' (Braun & Clarke, 2006). This means that just because a particular topic might have occurred frequently in the data set it was not necessarily coded as a category, but rather salient themes in the data set were coded when they became relevant to the analytic question. Nevertheless, the prevalence of data items was made reference to in the write-up of the report in order to support transparency and to go beyond discursive descriptors such as: "a lot of participants said".

The coding procedure and the resulting codes were audited predominantly at the initial stages of the research through the supervisory process and some extracts also by a colleague familiar with the employed methodology. Auditing was achieved by reading the original transcripts and commenting on the fit between the transcripts and the emerging codes. Further, the auditors suggested potential additional themes and analytic hunches which I attended to in any further analysis. For example, one of my supervisors commented on the potential theme of power imbalance between practitioners and clients. I subsequently decided that while there were some examples of this, they did not merit the creation of a (sub-) category.

Given the exploratory nature of this study I did not make use of a coding paradigm, such as axial coding (Corbin & Strauss, 2007) as I wanted to focus on the construction of theory from actual data and my own assumptions and were deemed to be reflected sufficiently in the interview schedule.

1. The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the recording for 'accuracy'
2. Each data item has been given equal attention in the coding process.
3. Categories have not been generated from a few vivid examples, but instead the coding process has been thorough, inclusive and comprehensive.
4. All relevant extracts for all each category have been collated.
5. Categories have been checked against each other and back to the original data set.
6. Categories are internally coherent, consistent, and distinctive.
7. Data have been analysed/interpreted, made sense of, rather than just paraphrased or described.
8. Analysis and data match each other/the extracts illustrate the analytic claims.
9. The analysis tells a convincing and well-organised story about the data and topic.
10. A good balance between analytic narrative and illustrative extracts is provided.
11. Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
12. There is a good fit between the described method and reported analysis.
13. The language and concepts used in the report are consistent with the epistemological position of the analysis.

Fig. 2: Quality Criteria for Coding and Analysis

Personal Reflexivity

Throughout the early stages of the analytic process, I was surprised about the extent to which the interviewed research participants seemed to practice in a highly idiosyncratic way with few patterns in terms of 'therapeutic tasks'. Especially as one of my initial questions had been whether a model of therapeutic work could be developed on the basis of my research, this was significant. Coding practitioners' accounts I was struck by the complexity of the concepts and participants ease of moving within their work context. At times, at least initially, it felt almost disloyal towards the data to categorise the rich complexity and interrelatedness of accounts, especially as the overlap between my initial different categories was substantial.

Over time however, more stable patterns emerged: however these were clustered less around therapeutic tasks but more around the kinds of dilemmas and tensions that

practitioners encountered. It was partly this finding that shifted my focus away from therapeutic tasks and methods towards practice dilemmas. However, the consistency with which practitioners talked about practice dilemmas also meant that subsequent amendments to the sampling strategy and the interview schedule were more limited than I expected and were mainly completed to check whether the emerging consistency was attributable to my own influence in the research (e.g. in the interview schedule, way of asking questions, etc.). I attributed this to the high cultural competencies of the recruited participants as well as their mostly shared training at two training institutions and their similarity in terms of their professional experience.

4.3.7.Memo Writing

As part of the analytic process, I used memos to note down any thoughts, ideas, processes, questions, leads and relationships about the developing codes and categories (Charmaz, 2006). As the categories began to develop, specific comparisons between or within categories and codes both within and between participants were made to decide which categories were more prominent and could become major and which should remain minor. This process was based partly on the memos, as was the process of elevating focused codes to categories. Indeed, the text in the memos was a primary source for the final categories and the final version of the grounded theory grew mainly out of these memos. The memos also served the purpose of monitoring my own reflective involvement in the analytic process (see Appendix IX for an example of a memo).

Personal Reflexivity

Particularly, in the construction of the category 2, 'EPP in Primary Care' memos played an important role. The process of writing memos with various different topics, some more and some less related to this category, significantly contributed to my awareness of the implications of researching within a post-modern epistemology: rather there being a single, unique narrative that I needed to 'find', I realised the potential for a number of possible narratives that all make sense of the data in slightly different ways. This encouraged me to make more 'bold' analytic and interpretative choices that relied more on my overall understanding of the data and the intuition I had developed through previous micro-analysis, rather than on micro-strategies where I tried to match-up different participants' accounts in the 'right' way. At times, this led me far away of the initial coding into a complete re-organisation of codes (especially in category 2) but resulted in an analysis that represented the 'spirit' of the data (and practitioners' accounts) rather than merely its content. Doing this also required checking back to codes and data to make sure that I was not writing a narrative unrelated to the data, but it brought about a more creative and free interpretative analytic process and I found new relationships in the data that the initial coding procedure did not illuminate.

4.3.8.Constant Comparative Analysis

Constant comparisons (Willig, 2008) were made throughout the entire analytical process: having identified common features that unite instances of a developing phenomenon, I then refocused on differences within categories and focused codes in order to be able to identify emerging subcategories and in order to counterbalance narratives that are “too tidy”, or the absence of potentially relevant aspects.

Part of the constant comparison was formed by the process of paying particular attention to negative cases that is, instances where the phenomena did not fit with the developing categories. This included sampling for further data that had the potential to contradict the developing constructs in order to provide further validity. This did not take place within a Popperian paradigm (Corrie, 2000; Pidgeon & Henwood, 1992) that aims at generating knowledge through the falsification of alternative theories, but rather in the spirit of elaborating emerging claims to further solidify a theory grounded in the data. In the analysis section, for example the opinions of individual practitioners are outlined if they stand against the general trend in the data. For example, one of the participants pointed out that the primary care setting resulted in ‘worse’ EPP, a view that was not shared by other participants, even upon further sampling. Therefore, I decided to include this statement in the analysis but also make reference to the fact that on the whole this was not representative of participants’ attitude.

Charmaz (2006) points out the dilemma between Grounded Theory’s aspiration of a ‘complete’ account and the risk of fragmentation if constant comparative methods are employed *ad infinitum*. For the present research, the measure of extending the comparison was defined by the extent that this is useful for the questions being asked of the research: it is recognised that the field of existential-phenomenological practitioners is and will remain diverse and that there is no ultimate theory describing how they negotiate their practice, however within this diversity tendencies were developed that might be useful for practitioners in the future. An important measure of comprehensiveness came from the participants themselves: when asked during the verification check, they found that the resulting grounded theory overall represents their experiences accurately and does not exclude any significant areas. One of the participants articulates this as follows:

Albert: I think there are maybe ways in which [...] we could continue to engage with the process of making meaning of the experience of being in primary care and lots of different ways in which we can sort of draw fresh narratives around that, but didn't feel like there were any glaring omissions (FG, 1:05:55 - 1:06:23)

Personal Reflexivity

One of the challenges in the analysis, especially the more interpretative aspect of the analysis, was to negotiate my prior experience within discourse analytic methods: my natural perspective, at least initially, was to look at the data in terms of the kinds of discursive strategies participants employed to achieve their discursive aims (e.g. Potter, 1996). While this helped me on a micro-analytic level, it also required me to consciously

focus on the wider social meaning and implications of participants' accounts as the focus of this research is on the negotiation of practice, rather than the construction of reality.

4.3.9. Member Check

Subsequent to analysing and developing a preliminary theory from the individual interviews, a focus group was conducted with a subset of participants who took part in the individual interviews. The focus group was principally employed as a member check to increase the validity of the grounded theory and to correlate my analytic interpretations with the experiences of participants. The aim was not to find consensus, but rather to triangulate and challenge my analytic procedure and to find out where my analytic rationales lacked rigour. Throughout the analysis notable points that emerged from the focus group are incorporated within the narrative of the overall theory. A further aim of the focus group was to generate a climate of collaborative reflection (Schön, 1995) and feed back on the findings of the research. In this sense, the stated aim of disseminating the findings of this research in practice-relevant contexts was partly achieved. Both participants and I experienced this as rewarding and participants commented on how this enhanced their own reflective practice.

Tony: [...] you articulated and brought something together which has made me think much more about that process than I was actually able to do, say during the interview. Uhm, and that in itself, there is another process in there which is really relevant to the whole project in terms of how we look at things. And how time does affect stuff and how when it's fed back to us in a certain way through another lens, there is lots of other thoughts that come up for me (FG: 1:06:42 - 1:07:03).

In terms of the employed procedure, participants were asked to read a summary of the findings (see Appendix VII) prior to the focus group and relate this to their own experience, by highlighting in the text aspects that corresponded to their experience, underlining those that did not and commenting on the comprehensiveness of the theory put forward. This was used as a starting point for a focussed conversation within the actual focus group. This method was used to make efficient use of the limited time (90mins) of the focus group and in order to capture the diversity of participants' voices. It also allowed me to facilitate the focus group in a more exploratory manner, to discuss salient experiences in more detail, rather than having to make sure that all of participants' experiences and accounts were given attention in a short space of time. Further, it increased the validity of the analytic conclusions. Analysis of this process was based on both the transcript of the focus group and participants' comments on the summary of findings. Grounded Theory methods explicitly support both member checks and gathering data from different sources (interviews, text, etc.) (Charmaz, 2006) and therefore this way of data collection was consistent with the research methodology.

My own role within the focus group was that of a facilitator of the discussion rather than an active collaboration. However, towards the end of the focus group when the discussion of the findings had been completed, I also shared with participants some of the rationales that lead me to analyse the data in the way I did.

In response to a request from two participants that were unable to attend the focus group, this process was repeated on a one-to-one basis and two further individual interviews were conducted. Therefore a total of seven out of the overall nine participants took part in the member check.

4.3.10. Quality Criteria

As Lincoln and Guba (Lincoln & Guba, 1985) point out, checks and balances in the research design can support the validity and trustworthiness of the research. Overall, quality criteria in qualitative research can be seen in terms of the transparent insight they provide into the procedures that have been employed so that the reader can retrace and understand the process that lead to the particular findings (Charmaz, 2006; Elliott, Fischer, & Rennie, 1999; Mcleod, 2003; Pidgeon & Henwood, 1992). Specifically, seven quality criteria are deemed relevant to this particular project:

1. Fit with participants accounts

As Pidgeon and Henwood (Pidgeon & Henwood, 1992) but also Strauss and Corbin (Corbin & Strauss, 2007) argue, it is of paramount importance to keep a good fit with participants accounts. This includes avoiding leading, closed questions throughout the interview. Further, this research uses participants' language, for example, practitioners across the entire data called the people they work with clients, and I adopted this term. Extracts of participants' verbatim account are provided throughout the analysis for the reader to be able to evaluate the validity of the findings. Overall, the accuracy of my work is further established through research supervision and also through peer-supervision whereby peers knowledgeable in this area of research have commented on extracts of my analysis. Indeed, this has led to substantial changes in the structure of the analysis section in order to provide clearer accounts that are more grounded in participants' accounts.

2. Rich accounts of varying levels of abstraction

Secondly, the data was analysed at a number of different levels from the initial coding phase that resulted in a number of 'in vivo' codes and subsequently more inclusive and general codes and finally more abstract theory development as opposed to providing merely descriptive material (Corbin & Strauss, 2007). In this way, theory development relates the richness of participants' accounts to dense and more abstract theory.

3. Reflexivity

As discussed earlier, the present research is underpinned by a strong reflexive element in order to be sensitive to the researcher's impact on and involvement with the research process thereby allowing for the reader to be able to judge the validity of the claims made (Elliott et al., 1999). Firstly, the design of the present research makes explicitly use of the

insider perspective of the researcher in order to conduct the sampling, develop appropriate interview questions and to be sensitive to the participants experience (Shaw, 2010). The relevant sections of the research report contain reflexive notes. Secondly, ongoing reflective engagement with the research includes brief note-taking, in line with what Glaser (Glaser & Strauss, 2012) has termed theoretical memoing: I recorded any insights or ideas as theoretically coded relationships as they emerge during the coding, collecting, and analysing of participants' accounts. I also recorded personal reflections and rationales for methodological decisions. Thirdly, I asked a colleague familiar with the area of my research to interview me on the questions I asked my participants in order to understand and clarify my own assumptions that I brought to the interview with the participants. Although this interview was not transcribed or analysed in a rigorous fashion analogous to the research interview, the process of reflecting and articulating my own thoughts and reactions to the research questions was helpful to situate myself within the research project.

4. Documentation

McLeod writes about the importance of adequacy of information given about the context of the study and the procedures employed (McLeod, 2003): therefore the procedures involved in sampling, interviewing, analysis and development of findings were documented extensively in the relevant sections and evidence of this documentation is shown in the appendices through letters to participants, extracts of analysed data and memos. This includes "situating the sample" (Elliott et al., 1999, p. 221) in terms of the demographic and professional context of participants, i.e., gender, age, years of professional training and type of training.

5. Credibility checks: Theoretical sampling and constant comparative analysis

In order to increase the validity of the current study sampling, data collection and analysis followed closely established Grounded Theory procedures as outlined previously, particularly theoretical sampling and constant comparative analysis.

6. Sensitivity to the negotiated reality

Pidgeon and Henwood (Pidgeon & Henwood, 1992) talk about the importance of sensitivity to the negotiated reality: the notion of validating knowledge through the research participants themselves. While there is some discussion in the field about the validity of this approach, particularly in terms of the independence of the research process and therefore the findings from any implicit or explicit agendas that participants might have (Cutcliffe & McKenna, 2002; Fereday & Muir-Cochrane, 2006) the perspective taken in the present study follows the argument that research should have meaning for both the researcher and the participants. Therefore, the previously outlined member check was conducted.

7. Transferability

Qualitative research (Altheide & Johnson, 1994; Lincoln & Guba, 1985) seeks to establish transferability: the potential applicability of the insights gained in contexts beyond the particular and idiosyncratic context of the present study. This is of particular importance in a counselling psychology paradigm which aims at producing knowledge and insights of practical applicability (Woolfe et al., 2010). Charmaz' (2006) notion of 'usefulness' encompasses the extent to which a Grounded Theory can answer questions useful in practice, the extent to which it suggests generic processes beyond the study context and sparks further research as well as contributing to knowledge. In order to sketch out some answers to the question of transferability, the present study enquires into the significance of the findings for the wider context of clinical practice, research and counselling psychology throughout the findings and discussion chapters.

In addition, Kvale (Kvale & Brinkmann, 2009) argues that new interpretations and meanings can alter the understanding of the participants and the validity of theories can thus be tested by examining the quality of practices they inform and encourage.

A valid qualitative account would, from this pragmatic "phronetic" perspective, be one that contributed fruitfully to the public discussion about values and goals in society" (p.257).

This is encapsulated in my interview by asking the participants about the interview process, by giving them an opportunity to reflect on their practice and by scrutinising the results during the member check and also by reporting the findings with the aim to disseminate the results in relevant contexts such as academic journals, conferences and training.

4.3.11. Ethical Considerations

In the final section of this chapter, the research process is appraised from a research ethics perspective and potential ethical issues are considered.

Research approval

While the psychological implications for the participants were not anticipated to be in any way harmful and the participants are not deemed psychologically vulnerable, both the British Psychological Society's 'Guidelines for minimum standards of ethical approval in psychological research' (BPS, 2004) and the 'Good Practice Guidelines for the Conduct of Psychological Research within the NHS' (Cooper, Turpin, Bucks, & Kent, 2004) were adhered to. In addition to university ethical approval (Appendix I), the North Central London Research Consortium (NoCLoR) was approached but it was deemed that no ethical approval was required for interviewing current or former NHS staff. Research and Development approval was granted in order to allow for recruitment a North London NHS Triage Team, but due to departmental restructuring no participants were recruited from this trust and therefore the research was withdrawn from the NHS Research and Development process.

Informed Consent

Participant's consent to participate was established before the interviews and throughout the research process. The voluntary nature of participation and the right to withdraw at any time and the right not to answer all questions was emphasised throughout the research process. The participant information sheet (Appendix III) gave details about the collection and analysis of data, the confidentiality and protection of anonymity, and the rights of the participants to withdraw at any point. Informed consent was obtained in writing from participants prior to commencing the study (Appendix IV). It is acknowledged that informed consent cannot be fully given in advance, because the full scope of the process of research is not determined in advance, therefore consent was negotiated continually throughout the research (McIntyre, 2008) at key stages: at the beginning and end of each interview/focus group consent was re-confirmed.

Potential Risks

The potential for distressing emotions during the individual interviews or distressing group dynamics within the focus group was deemed minimal, especially as all participants were trained mental health professionals with access to, and experience of using support systems. Despite this, consideration was also given to the fact that by participating in the focus group participants were not anonymous to each other and that differing opinions might give rise to concerns about anonymity or might present distressing group dynamics. In addition, it was taken into account that some of the participants had worked within the same Primary Care Trust and trained at the same institution and therefore might know each other which might impact on their experience of anonymity within the focus group.

Therefore, concerns regarding the research process and any other outstanding concerns were offered to be discussed prior to the commencement of the interview and after the termination of the interview. Participants were offered to withdraw their statements at any point. In addition to this, participants were given a de-briefing sheet (Appendix V) with the contact information of the researcher, my supervisor and sources of psychological support. I enquired informally and separately with all participants after the end of the focus group as to their experience of being in this group and whether this had any impact on their willingness to remain part of the study.

Additionally, participants were reminded that they continued to be bound by their professional standards concerning the disclosure of client material and identification of clients as part of the interviews. Equally, care was taken on behalf of the researcher to identify any instances where confidentiality might have been breached and to delete such instances from the final data. However, this did not materialise.

Participants were interviewed on the premises of Middlesex University and a risk assessment for participants and the researcher undertaken before interviews took place.

All data gathered remained entirely confidential, data was anonymised before the transcription and analysis. In the write-up of the thesis, anonymity was preserved.

Identifiable information was removed or altered sufficiently to protect the participant while at the same time being aware that confidentiality might not be fully guaranteed due to the unique position of the small community of existential practitioners within which this study takes place. The participants were made aware of this and given the opportunity to edit information that might identify them.

Participants were also informed about the potential benefits of the research such as the provision of a space for practitioners to reflect on their experiences. Indeed, several practitioners commented on the usefulness of the research process to reflect on and make sense of their experiences. Lindsay for example, commented on the usefulness of reading and discussing a summary of the findings as part of the focus group:

Lindsay: And if anything, it summarises some issues that I have struggled to articulate, so it was a helpful thing (FG, 1:06:23 - 1:06:43).

Power Dynamics

Finlay (Finlay & Gough, 2003) points out that the researcher plays a dominant role in the research, deciding on the questions they ask, the participants they interview and those accounts that are left out of the research report. This results in a power differential between the interviewer and the interviewee. Particularly, in the current research design, the participants were encouraged during the interviews to articulate their identity and therefore make it known to the interviewer and become vulnerable to the interviewer-imposed categories and questions without wanting to. Particularly, during the pilot study this occurred on a few separate occasions, where my particular take on the interview questions had the potential to impose a particular truth on the participants as the interview schedule had not been tested under 'real-world' conditions yet. Further, I was aware from the beginning of the potential that my interest in this particular topic might make participants feel that they need to come up with positive experiences. This was specifically countered by asking clients about the tensions and difficulties they experienced.

On the other hand, the interview can also be liberating in the sense that it provides a space for the interviewee in which he/she can explore their position free from the usual contexts, e.g. the context of working with clients, the context of being with other professionals (McCabe & Holmes, 2009). The participant can become an expert in the topic while the researcher solely represents a facilitator, by encouraging the interviewee to seek knowledge rather than judgment of themselves. Indeed, several participants likened the interviews to the process of supervision, enabling them to achieve clarity in understanding.

The skills that I acquired as part of my professional training, in terms of bracketing my own preconceived understanding and enquiring into the reactions that people have in relation to others contributed fundamentally to the process of becoming aware and managing the power dynamics that became apparent throughout the research.

At the same time, it is also worth noting that unlike some forms of research where the researcher is an expert in the research field, the power structure in the current research is somewhat more equal: both the researcher and the participants have some experience working as therapists within a primary care environment. While my expertise was enhanced by my engagement with the topic in a systematic way, participants often had similar or related expertise (e.g. with short-term work, or work within the NHS). In addition, their professional training allowed them to resist any positioning on my part and to recognise power dynamics (Hemsley, 2013a). In order to balance the power dynamic further, I encouraged participants' stake in the project. To this end I used an open-ended method, semi-structured interviews and. I fed back the results of my analysis to all those participants interested and as part of the focus group I gave them an opportunity to feed back their responses.

Of particular note is my previous collegial relationship to three of the participants: both in terms of the potential for unreflected shared understandings but also in terms of the potential for situations to develop where participants might feel coerced to participate or continue to participate in order to maintain good social relations me: I endeavoured to be sensitive to any situations where this might occur as well as making sure that the communication between myself and former colleagues adhered to the same strict guidelines as other participants, e.g. in terms of research participation requests and follow-ups. In addition, I asked for feedback on our relationship from former colleagues. I approached the interviews with former colleagues from a curious perspective and my experience was indeed that any previous relationship only manifested in the extent to which participants felt comfortable to give me an intimate and personal account of their experiences. I particularly made sure that I was open to potentially unreflected mutual understandings such as when participants assumed I knew a particular practice context and queried these as part of the interview process.

4.4. Conclusion

The method, procedural steps as well as the ethical considerations described above were integrated on the basis of the outlined epistemology to form the research methodology for this research. This methodology was employed to sample and analyse nine individual interviews with practitioners practicing existential therapy in primary care. Results from the analysis were fed back to a subsample of five of the original participants in the form of a focus group and a further two of the original participants in two separate individual interviews. From this, a grounded theory of the negotiation of existential-phenomenological practice in primary care was constructed which is presented in the following chapter.

5. ANALYSIS

I am channelling a bit of a sense of something a bit Nietzschean about the idea of you know, we can sit here and we can talk about life in a serious way. And we can do that from the first session somehow. (Albert, research participant)

The analysis chapter introduces the general structure of the theory that was developed on the basis of the data collection and analysis, as well as the demographic data of participants. Subsequently, the major categories and minor categories making up the grounded theory are discussed in detail.

Interviewees' accounts across the entire collected data are characterised by attempts to define and negotiate practitioner's professional practice within, and frequently against, the context in which they work. One of the central threads that runs through the analysis of the collected data revolves around practitioners' experience of 'otherness' within the primary care environment and the process of navigating a fit between the setting of primary care, the existential therapeutic tradition and practitioner's own way of practicing.

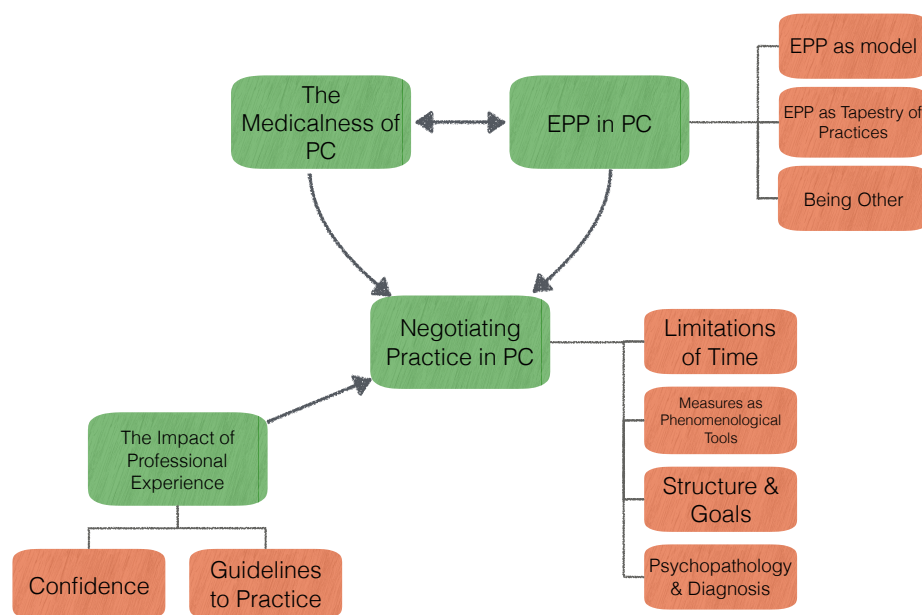


Fig. 3: Categories of the Grounded Theory

Specifically, the analysis of the data gained from the interviews consists of four main categories (see green elements in Fig.3), some of which have further subcategories (see red elements in Fig.3): the first category describes the setting of primary care as a context

to the practice of existential-phenomenological practice which makes certain demands on practitioners. The following category describes practitioners' positioning in regards to existential-phenomenological practice and the setting of primary care as well as how this defines practitioners' identity in terms of being 'Other'. The third category describes four main ways in which practitioners manage and negotiate the presenting practice dilemmas as part of their growing experience of the primary care setting. The fourth and final category particularly focuses on the impact that professional experience has on the outlined processes.

At times, the ways in which practitioners engage in the negotiation of practice are contradictory on the surface, however on closer inspection they reflect practitioners ambivalent and multi-faceted perspectives on the tradition of EPP. In the writing up of the analysis I endeavoured to follow a narrative that brings together the data as a whole and makes the complexity of practitioners accounts intelligible on hand, while on the other hand also respecting the richness of diverse and at times conflicting accounts.

5.1. Demographic Participant Data

As a result of the sampling strategy, nine individual practitioners were interviewed and seven of those took part in the member check to validate the findings: five as part of the focus group and two further interviewees fed back their views in separate individual follow-up interviews.

Due to the small size of the existential community, particularly existential practitioners working in the NHS and in order to facilitate anonymity no detailed description of individual participants is given. However, a general overview of the sample characteristics is outlined.

Among the nine interviewees there are four female and five male participants, aged between 29 and 50 years with a median of 36 years. Participants are from a variety of national backgrounds, however practitioners trained in existential therapy or counselling psychology in the UK. Eight participants are White British or White Other and one participant identifies as Asian.

All participants identified as practicing in an existential-phenomenological informed way, despite having trained in other modalities including person-centred, psychodynamic, cognitive-behavioural and integrative psychotherapy. Due to the difference in training structure it is complex to report on the exact amounts of time participants trained in existential therapy, however all participants trained a minimum of 4 years at university level, either as part of a postgraduate diploma, masters or doctoral programme.

All participants attained a minimum professional training at postgraduate diploma level in psychotherapy; three participants have a masters in psychology or psychotherapy. Four participants are currently in the final year of their training towards a qualification in counselling psychology.

All but two of the participants in this study have worked in a primary care setting as part of their training, but only one of the participants is currently employed within primary care. Length of experience in primary care ranged from one to over five years with a median of one and a half years and this experience was gained within the last five years for all practitioners. Two of the practitioners describe primary care as their first clinical placement as part of their training.

Four of the participants worked in the same primary care trust, however not always at the same point in time. All other participants worked in separate settings.

Six participants have experience within NHS settings other than primary care either as part of their training or as post-qualifying work place. All practitioners are currently practicing as therapists in a wide variety of settings, including private practice, NHS services, third sector services, university contexts or social care.

Therefore, a typical participant within this study is ethnically from a White background, in his/her mid-thirties and has studied existential psychotherapy in the UK (either at the New School of Psychotherapy and Counselling or at Regent's University) for around 4 years. He/she has practiced existential therapy as trainee within a primary care service and has experience of practicing in other NHS contexts. He/she is recently qualified with a postgraduate qualification in psychotherapy, identifies as an existential-phenomenological practitioner and currently practices as a therapist however not in primary care.

Interestingly, the recruited sample remained skewed towards practitioners who gained experience of primary care throughout their training despite advertising on mailing lists for qualified practitioners and also at a national conference. On one hand, this is not surprising as primary care forms an important training setting (Ramsey-Wade, 2014) on the other hand, I would have expected to find more participants who work in primary care post-qualification. In the absence of any figures of practitioner population in primary care it is difficult to theorise about this. However, the shift of service delivery in primary care towards IAPT with its preference for cognitive behaviourally trained practitioners might account for part of this. All of the interviewed practitioners were positive about their experience in primary care and many voiced that they would go back were there any opportunities.

5.2. The Medicalness of Primary Care

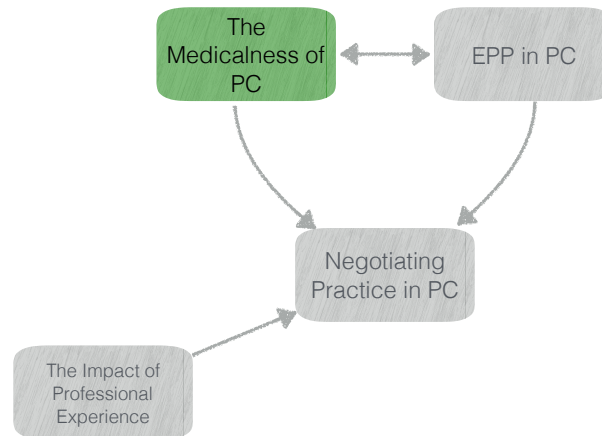


Fig 4: The Medicalness of Primary Care

The first major category describes the setting of primary care in terms of the background and context in which practitioners' professional practice takes place. Beyond providing a background however, the primary care setting also enters the therapeutic space that practitioners create with clients in a number of ways, thereby creating demands on practitioners and their practice. These are varied, however mostly clustered around the theme of 'medicalness'. Between five and 40 percent of individual practitioners' accounts were coded within this category with a median of 18 percent.

Across the interview data there are rich descriptions of the particular contextual features of the primary care environment. The organisational setup in terms of the type of service practitioners work from vary to some extent: settings include NHS primary care mental health teams (5 practitioners) and IAPT services (4 practitioners) as well as a primary care psychotherapy service provided by an organisation external to the NHS (3 practitioners). Apart from the IAPT services, which are located within dedicated premises, all the other services are physically located within GP surgeries.

Despite these variations, practitioners overall describe the context of this environment uniformly in terms of two main aspects: in terms of the concretely tangible physical setup and the corresponding organisational procedures on one hand and in terms of less tangible but no less important "atmosphere" (Robert, 3:35), the underlying values and "ethical edges" (Albert, 20:00) on the other hand. Albert alludes to the former in the following extract, whereas Robert alludes to the latter in the second extract:

Albert: [...] and how I would manage the fact that there is a blood pressure [inaudible] and there is a stethoscope floating around [...] and even things like the individual's GP's room had particular little prints which were all prints of classical physician patient scenarios. (12:32 - 13:31)

Robert: So, I was in a GP surgery [...] and obviously being in a GP surgery it has a slightly different atmosphere to, for the fact that people are turning up, I think people are more used to turning up to a GP surgery to go and see a GP, for a medical issue as opposed to uhm, sort of psychotherapy or counselling, as sort of non-medical intervention. (3:32 - 5:01)

In terms of the concrete setup, interviewees describe clients to be referred to the particular service via the corresponding GP; sometimes clients are assessed by a senior clinician before being referred to the individual practitioner (4 practitioners), sometimes the practitioner undertakes this initial assessment. Clients sometimes arrive with psychiatric diagnosis such as anxiety, depression, trauma, agoraphobia, etc., but none of the interviewed practitioners described diagnosing clients. However, diagnosis is sometimes used as access criteria for onward referrals and diagnostic labels feature frequently in practitioners' talk about the determining aspects of primary care.

Alex: I mean I might get somebody who had a previous diagnosis. But it was very rare that it would have been somebody all of a sudden acquired the label within our team. (26:28 - 28:04)

Practitioners frequently talk about the length of time and the session numbers that they are able to provide to clients: typically, practitioners offer between 6 to 10 sessions of therapy, which is determined by the service protocols, rather than by individual practitioners, with the exception of occasions when clients chose to leave before the end of their allocated sessions. Only two practitioners talk about increasing session numbers, usually because it is felt that clients need more time to build a stable relationship with the practitioner.

Practitioners also frequently make reference to the setting of goals for the therapeutic work and measuring therapeutic progress and outcomes through the administration of service-determined psychometric scales such as the PHQ-9, GAD-7, CORE system and the Social Adjustment Scale.

Alex: I was forced to do...so, I uhm, had to do a CORE form in the first session and the last and PHQ-9 and GAD-7 and then in the sessions either side of the first and the last there was PHQ-9 and GAD-7. (42:29 - 42:58)

These physical and procedural characteristics of the primary care setting are also posed to exemplify the underlying values of this setting. Corollaries of the latter are certain (albeit often unarticulated) rules and ways of working, a certain language and a particular culture that underlies primary care.

Patrick: I think that that, kinda technocratic language, flows through, uhm what it means to work in primary care. (17:00 - 18:46)

This culture is set up as impersonal, technocratic in the above extract, and has a 'technical' as opposed to a 'human' feel. Thus, it operationalises psychotherapy and mental health care.

Patrick: Utility is everything, you know, was it effective? Did it happen? (14:40 - 14:47)

From a micro-analytic perspective, practitioners tend to draw on language taken from medical-scientific vocabulary when talking about the primary care, such as, ‘patients’ instead of ‘clients’, ‘recovery’, ‘cure’, ‘treatment plan’, ‘care’ and ‘protocols’ which creates a certain generic and technical feel that distances the primary care as a setting from the human element that practitioners bring to their practice. In fact, practitioners’ tone is often somewhat dismissive:

Robert: I mean the nice thing about working with an existential approach with an existential supervisor is, it's not the kind of LAPT you know, “complete recovery” whatever the hell that is. (9:34 - 12:34)

Overall, practitioners’ accounts on the outlined physical, organisational aspects of primary care and its underlying values and culture, describe this environment to stand fundamentally in the tradition of what is referred to as the ‘medical model’ by many participants. Practitioners’ accounts therefore frequently serve to illustrate the ‘medicalness’ of this environment. Susanna summarises this very clearly in the following extract:

Susanna: [...] you are not asked to work in a certain way, but the sessions are limited, uhm there is an idea that the client arrive and they expect maybe to see some progression and to have a result, uhm they expect you to be an expert in something, uhm all this kind of, uhm, medical model, scientific framework, uhm comes with that, working in that place. (6:52 - 7:33)

While practitioners’ accounts are specific to primary care, often practitioners construe the particular context of primary care to be standing within the larger context of the “structure and system” (Robert, 2:58) of the National Health Service. As a result, the medical traditions in which primary care is construed to stand, and the particular primary care context and even the NHS in general are frequently conflated. While I speculated at earlier stages of this research that this might be an artefact of participants lack of understanding of the NHS structure or of the way the interview questions were framed, later interviews with amended interview schedules and with participants explicitly referencing their understanding of NHS stepped-care models (i.e. primary, secondary, territory care) confirmed the early-stage analysis: participants see the medical model approach to human concerns as a fundamentally defining feature of primary care. Specifically, as outlined above, the limitations in time, the notion of setting and achieving therapeutic goals, the measurement of therapeutic progress and outcomes through the use of psychometric tools as well as the use of diagnostic categories and labels are construed as defining features of this version of the medical model in primary care.

However, as can be seen from Susanna’s account above, but also in the other extracts cited in this section, the outlined contextual features of primary care, in their ‘medicalness’ move beyond forming a mere background for the foreground of EPP. Rather, the primary care context is fundamentally perceived as relevant to practitioners as Tony succinctly describes:

Tony: [...] there was an assumption that they were seeing a kind of medical person there, a doctor of sorts. And...which sets up expectations and medicalises what I am doing. (5:18 - 7:01)

Primary care as a practice context evokes a response (both emotionally and practically) and makes demands on practitioners and their way of working: primary care is construed as enabling certain ways of working such as working to a set number of sessions, working with goals and psychometric measures and with diagnostic categories. The ‘medicalised’ primary care setup also imposes certain practices as for example, Alex points out above, when he talks about being “forced” to work in a particular way.

As a result of the demands that the ‘medicalness’ of the primary care milieu makes on existential-phenomenological practitioners and practices, participants describe entering into a dialogue and negotiation with this context that, in turn, impacts their way of working in a variety of ways. The nature of this negotiation is outlined in the third category of this grounded theory, after a more detailed exploration of EPP in primary care as both a therapeutic model and set of practices.

5.3. Existential-Phenomenological Practice in Primary Care

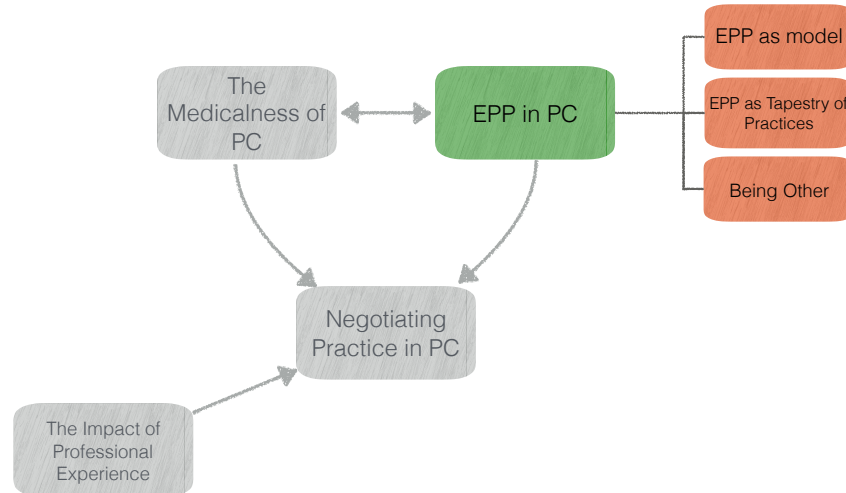


Fig 5: Existential-phenomenological Practice in Primary Care

As outlined in the previous category, EPP in primary care is not experienced as ready-to-hand, as ‘EPP-in-PC’ that is, as an intervention that is integrated with its context. Rather, practitioners often, at least when describing their initial experience in primary care, describe EPP in a context-free way, as an entity or phenomena for itself that has certain characteristics.

Principally, EPP is framed with reference to two different aspects: interviewed practitioners frame EPP both as a shared model of practice but also fundamentally flexible and responsive tapestry of practices, which take their main structure from the interaction with individual clients. The existential-phenomenological attitude integrates both these aspects in a flexible and responsive way.

However, posing flexibility and responsiveness as central characteristics places EPP in contrast to the medical model underlying the primary care setup. As a consequence, practitioners often experience the need to justify their way of working which often makes them feel *alien* thereby positioning them as outsiders within primary care. The term ‘otherness’ was adopted to describe this process and to describe how practitioners experience their practice not as ‘same’ but as ‘different’ and ‘other’. *Otherness*, supplies practitioners and their practice with an identity, while also presenting a central tension in their work.

Between two and 27 percent of the data is coded within this category with a median of twelve percent.

5.3.1. EPP as Model

Throughout the data, practitioners frequently talk about EPP as a ‘way of working’, an ‘approach’, or a ‘model’ with particular characteristics, namely as a type of psychotherapy that draws on existential traditions and the phenomenological method and is delineated to other approaches. These characteristics are outlined in the following.

First of all, EPP in primary care is constructed to firmly lie within the boundaries of the psychological therapies and indeed make fundamental use of its traditions. Practitioners draw their professional identity from the tradition of psychotherapy (‘therapist’). Surprisingly, only one participant makes reference to standing in the tradition of (counselling-) psychology, even though four of the interviewed participants are within the last stages of training towards a qualification in counselling psychology. In the follow-up interview, one of the practitioners mentioned that the fact that she had not completed her counselling psychology training at the point of working in primary care made her reluctant to lay claim to this profession.

As a result of taking on an identity as therapists, traditional psychotherapeutic ways of working such as the fifty-minute session, the once weekly appointment, professional boundaries, etc. are accepted ways of providing psychotherapy and did not receive any questioning or challenging

Alex: [...] just it was worked out as making sense to me that certain therapeutic boundaries are useful. So, I suppose that I have gone along with it because it meets with my idiosyncratic experience. But it is useful that I have a 50-minute session because that is as long as my attention can last for. (16.15)

More specifically, practitioners characterise their ways of working as being based in existential and phenomenological literature, theory, philosophical assumptions and practices. To this end, they occasionally quote practitioners or philosophers who espouse these principles.

Patrick: The Spinoza-esque you know, phenomenological method, you know, the eidetic reduction and so on. And then, the kind of uhm, influence of a van Deurzen-type life-focus, you know the therapist as art-teacher, you know looking at the four dimensions. (21:58 - 22:23)

Practitioners refer to their work in general as existential-phenomenological; at times they distinguish between existential and phenomenological dimensions of their work. This happens mostly when highlighting particular aspects of their practice. The term existential is mostly used when relating particular aspects of clients’ concerns to the wider context of being human. The term phenomenological on the other side is more often used in an active way, as a process and a way of working with clients. Practitioners frequently talk about working phenomenologically when they recount an exploration of the clients’ concerns, experiences, feelings, in a way that emphasises the client’s perspective as opposed to the practitioner’s perspective or other people’s perspectives. At times the terms are also used synonymously. The former is exemplified in the following extract from the interview with Natalie, the latter in an extract from Alex’s account:

Natalie: [...] feels more phenomenological, that isn't about a pre-existing list of categories that have to be covered, but is more about just more intense curiosity maybe. (47:11 - 48:19)

Alex: so I suppose the bit that is existential and phenomenological is that we are all approaching it from a general attitude. (18:16 - 20:03)

The most fundamental aspect of the ‘therapeutic-ness’ of EPP is the relationship between therapist and client and this is also construed as the main agent of therapeutic change. Practitioners actively attempt to deconstruct any imbalances in power, between themselves as professional and experts but rather strive for a more equal relationship between two human beings; however with an emphasis on the subjective experience of the client rather than the therapist. Alex calls this “relational space”:

I find myself working a lot in the sort of intimacy of the relational space. So, uh, I will ask questions like: and what was it like saying that to me? And I will also ask things like: did you hear yourself say that and what was that like hearing yourself say that? (20:18 - 21:12)

On a micro-analytic level, practitioners use discursive strategies such as the word ‘us’ to demarcate their identity and situate it within the larger community of EP therapists, like Susanna and Alex in some of the extracts above. Indeed, working from within an existential-phenomenological model is construed to address somewhat different aspects of clients concerns than other therapeutic modalities as it’s emphasis lies on helping clients understand how their stance impacts on their experience of their concerns. Particularly, cognitive-behavioural ways of working and specifically the way these are implemented as manualised interventions in programmes such as IAPT served to contrast an existential-phenomenological approach, to a lesser degree also psychodynamic approaches, person centred, acceptance and commitment therapy and mindfulness.

Lindsay: I...knowing CBT I can definitively say I didn't do that then. (2:47 - 3:10)

However, with the exception of one practitioner, who underwent post-qualifying training in CBT at the time of the interview, the delineation to other approaches often does not contain the same richness in detail and specificity that practitioners show in their accounts on EPP, which might at least partly be attributed to the specific focus on EPP within the research interview schedule.

5.3.2.EPP as Tapestry of Practices

While EPP is construed discursively as a ‘model’ and delineated from other models, the analysis sets out that the actual practice of interviewees is more accurately described in terms of a multi-faced and integrated tapestry of EP ideas and concepts, centred around the presentation of particular clients. EPP’s diversity and client-focus is framed mainly with reference to three distinguishable, albeit related aspects: its multi-faceted philosophical and historical basis, the prominent role of the self-as-therapist within the therapeutic work and the idiosyncratic session structure. Practitioners’ work is based on their existential-phenomenological roots, but not determined or prescribed through these.

One of the themes that comes up in more than half of the practitioners' accounts is the notion that EPP is not seen as monolithic or unified but rather as flexible and responsive to the particular context. This means that practitioners draw on a wide variety of sources, which might include continental philosophers such as Heidegger, Sartre, Nietzsche, Kierkegaard, but also other practitioners such as Ernesto Spinelli or Emmy van Deurzen. Robert's account epitomises this diversity:

Robert: I mean, to talk about an existential approach itself is rather simplistic, there are existential approaches, there are lots of people who fall under the banner of existential, who work in very, very different ways with clients. (26:03.1 - 28:29.5)

Integration of the diversity of existential-phenomenological influences is achieved thorough a watchful, critical and curious stance on the phenomena that emerge within the therapy context.

However, very few examples of integrative practices are presented that draw on methods from outside the existential-phenomenological 'core' territory. Only two practitioners make reference to examples of integrating concepts, tools or techniques from other therapeutic models. Neither, have there been any references throughout any of the interviews to any of the published existential integrative models. Indeed, there is a general scepticism towards any form of systematic integration that is, where the decision to integrate different approaches is taken by the practitioner prior to the concrete encounter with the client or when integration relies of particular defined therapeutic tools and techniques. Practitioners are keen to point out the potential to compromise the unique relationship between client and therapist, by operationalising human relating

Albert: I am not going to apply a particular way of working with you. Uhm, or make choices about what I do or don't say that aren't part of the moment to moment emerging between us. [...] so any technique I bring to that is only so good as the degree of engaging that the person has. (1:05:12 - 1:07:11)

At the same time, practitioners commented, particularly in the follow-up focus group, that ad-hoc and implicit use of ideas and concepts that might form part of other therapeutic modalities does take place in practice. Especially, as practitioners gain professional experience and feel more confident to find ways of experimenting with their practice. However, this is accomplished without necessarily accepting other modalities' unique claims to such concepts: one practitioner pointed out that he might ask clients to experiment with their sense of self without aligning this to CBT's behavioural experimentation.

In terms of overall therapy structure, as well as the session structure, practitioners often reference how the imposed use of forms and psychometric measures in primary care structures the individual sessions, however beyond this, session structure as well as the structure of the course of therapy as a whole is almost exclusively determined in collaboration with clients and in response to their presenting concerns.

Alex: I mean there are things that happen at different points but when they happen, why they happen is idiosyncratic. (44:27 - 45:24)

Indeed, when practitioners talk about their work they tend to emphasise the idiosyncratic nature of the therapeutic process. This puts a focus on both client and practitioner as unique persons engaging in a unique encounter, rather than the roles that they might assume as client and therapist. As Albert says:

[...] we are two people sitting together struggling to work out what's happening. (1:05:12 - 1:07:11)

Practitioners frequently describe the use of their subjective experience, as a guide within therapy at each particular moment of therapy. The sense of self of the person who is working as a therapist is constructed as fundamental part of the therapeutic model and at times becomes inseparable from the existential-phenomenological therapeutic model it is grounded in. Practitioners in this study find it difficult or even unhelpful to separate their personal contribution from their therapeutic work as Alex points out:

Alex: I can't separate the things. I am me. And I am... and in this moment I am being therapeutic, but me. All the way through and that. (59:20 - 1:00:07)

Overall, practitioners' accounts point to a sense of connection or kinship to existential-phenomenological philosophy and practice, however the idiosyncratic meeting of the practitioner with a particular client at a particular point in time is framed as taking precedence over theoretical concepts, including existential-phenomenological theory. Rather than providing an *a priori* prescriptive framework, it “backs up” the way particular way of practicing.

Natalie: I feel like a lot of what I believed is good about therapy comes from EP ideas [...], I think I have a felt sense that that's how I want to work and that EP theory sort of backs that up, which is good, uhmm, but yeah it's quite organic. (39:25 - 40:21)

5.3.3. Being Other

Narratives of EPP as both a delineated approach but also a set of idiosyncratic practices run through the data of most interviewed practitioners. The analysis of the data suggests that both conceptualisations are experienced equally as aspects of EPP, even though there are only few accounts specific to this. Albert addresses this in the following extract, by postulating the necessity of a practitioner ‘stance’ and ‘attitude’ that both provides a delineation to other approaches but also integrates the diversity of sources that practitioners draw on:

Albert: [...] there must be a attempt in the attitude to maintain a structure of boundary, a stance, a position, even if that means from moment to moment I am engaging with where the client is coming from. Clearly the therapist has that. So, it's not a post-modernist free-for-all. It's post-post modern. (1:14:53 - 1:15:16)

It is this attitude allows for the flexible integration of the wide variety and multi-faceted existential and philosophical concepts.

Natalie: [...] that's sort of backs up the sort of attitude bit that I...I like that it's about finding yourself, reading lots and thinking lots and engaging personally lots and then sort of finding yourself in all of that stuff. (40:56 - 42:19)

In fact, framing EPP as an approach and as tapestry of multiple EP sources of inspiration, integrated through the attitude of the practitioner is frequently linked to providing freedom and flexibility to work in a way that is focussed on the client and their presenting concerns.

Lindsay: [...] there is a sense of freeness in this because I can step away from being the professional and now I have to be super clinical, but there is ubm, then the phenomenological side is more, I would want to give more time for somebody naturally and experience something. (8:47 - 9:22)

This is especially appropriate, as practitioners report to work with a wide variety of diverse clients and clinical presentations.

Susanna: Because first there is such a huge variety of people and also it's people who may not have come by themselves and I, ubm, some of them were just encouraged by the GP to come. (11:09 - 11:49)

However, posing flexibility and responsiveness as central characteristics creates a tension with the more rigidly set out organisational structure and procedures of the medical model underlying the primary care setup.

The medical framework, at least initially, is construed as “restrictive” (Albert, 30:43- 31:57) and “imposed” (Alex, 39:39- 40:25) rather than enabling. The underlying scientific and medical values of the primary care context are construed to lead to “rigid” (Robert, 22:04 - 23:54) and generic, or at least generalised, therapeutic help on the basis of formalised assessments and administration of treatments that reduces clients’ unique and complex concerns. Particularly, formalised procedures that are associated with the medical model, such as operationalising psychological interventions through the restriction in treatment length, the filling in of forms, the setting of therapy goals, the administration of psychometrics tests, the focus on determining treatment outcomes and “labelling” (Natalie, 26:03 - 28:27) clients with psychiatric diagnosis is seen to oppose the “flexible” (Patrick, 30:43 - 31:57) and “organic” (Natalie, 39:25 - 40:21) spirit of EPP. Albert, for example contrasts ‘paperwork’ associated with the medical model with ‘simply sitting’:

Albert: [...] so I want us to go through as much of the paperwork as possible in order for you to be able then to simply sit with me and discuss with me what, what's, where things are at for you. And be free of all of that and not try and drag you back into that from parts of your story. (36:23 - 37:51)

Even though some of the interviewed practitioners feel personally supported by other professionals in their workplace, generally the medical philosophy creates a tension within practitioners work. Practitioners pose a clash of values and a lack of fit. Alex, for example, poses a fundamental tension:

Alex: I think tension is a good word to...you know or a good thing to pick up on, where the tensions would lie between a medical model and a...being existential...because the two...two ways of approaching life clash...(1:05:34 - 1:06:05)

The tension between the values of EPP and those of primary care results in practitioners experiencing themselves and their practice as being “different” (Patrick, 6:47). This is frequently problematised and generally practitioners identify with EPP over the identity of being primary care clinicians.

Patrick: I felt different. To be brought, you know, in terms of being a psychotherapist in a service where, you know it's not really, you know it's not really well understood. (6:47-7:29)

I adopted the term ‘other’ and ‘being other’ from the writings of Sartre (1969) not only to articulate how practitioners feel ‘not-same’ with regards to other professionals and within primary care culture but also to convey the sense of ubiquitous dominance that the value-set of primary care exerts on practitioners.

The tension between EPP and primary care surprised me in its lack of ambiguity, given my own strong pluralistic counselling psychology identity and my own experience of feeling like a member of the primary care team. At the same time however, it provided support to the capacity of the analytic procedure to capture processes diverging from my own experience as ‘insider-practitioner’.

When talking about their practice interviewed practitioners across the entire range of data make reference to a need of making their work intelligible, of having to explain, articulate and at time even defend and justify their way of working and their role within the setup their work to clients, GPs and other professionals, including their supervisors. Tony alludes to this in the following extracts when he talks about being questioned about his approach:

Tony: Which obviously then for me was sort of a pressure to justify who am I and what is my role within this context. (7:09 - 8:33)

Indeed, the way in which EPP is construed as a systematic and internally consistent therapeutic model (see above) as opposed to idiosyncratic tapestry of diverse practices at times appears to serve the function of validating practitioners particular way of working within an environment that places value on generalisable procedures and ways of working. Robert expresses this tension:

Robert: [...] well if we think that this model is good for clients and since by far the largest market place is the NHS, why aren't we trying to sell the approach we have in this system. And to do that we need to be able to say this is what we do and this is how we do it. And this is what we can offer to these clients. (38:55 - 41:40)

This might be further compounded by the fact that while most of the interviewed practitioners discursively delineate their way of working from other models and modalities (such as CBT), there is little specificity in their accounts and they are often unsure about where they would place a line of delineation. The following extract from the interview with Lindsay exemplifies this:

Lindsay: And then I don't know whether they would be so vastly different to any other models, the principles [that characterise EPP]. (58:45 - 58:52)

On the other hand, one of the participants in the follow-up focus group highlighted the vagueness and lack of definition as significant part of EPP.

Albert: [...] well, it bloody well ought to remain vague. To some degree. Because otherwise it's a done deal, it's all nailed now isn't it. (FG, 46:56- 48:29)

Overall, *otherness* therefore emerges as a notion that both supplies practitioners and their practice with an identity by contrasting their 'attitude' to the values of primary care, while also presenting a central tension in their work. The urgency that results from this experience of *otherness* forms the backbone of the emerging Grounded Theory as it prompts practitioners to engage in ways to negotiate and navigate the perceived mismatch between the existential-phenomenological paradigm and the prevalent medical model in primary care. Alex, one of the interviewed practitioners alludes to this urgency in the following extract, where he talks about creating a document or training directed at other professionals within primary care. Notably, he uses the term 'we' to include not only himself but also the wider community of existential-phenomenological practitioners within primary care.

Alex: Yeah, I think the benefit would be ... so that we as clinicians would be better understood as to what it is that we are in fact doing. (1:03:34 - 1:03:54)

Rather than eschewing the tensions opened up by being 'Other' within the primary care setting however, practitioners enter into a dialogue, which is outlined in the following category.

Personal Reflexivity

Coding, analysing and writing up this category and outlining some of the core elements of EPP was a particularly challenging process.

Partly this was because of practitioners' discursive competence and their ability to condense complex and multilayered concepts and processes into their accounts and also because the reality of people's accounts and practices rarely fits neatly the hierarchical structure of scientific narratives.

However, at the same time, the difficulty I experienced in analysing practitioners' accounts also raised the question whether there might be a more fundamental, parallel process: the reluctance of practitioners' talk to fall more easily into a coherent theoretical account parallels some of the tensions that practitioners experienced in primary care. Indeed, practitioners in this study define the very core of their work to be idiosyncratic, flexible and contextual *praxis*, thereby standing in contrast to the 'essentialist' outlook of the primary care perspective that attempts to define and classify psychological therapy in the way 'medical treatment' is framed. Practitioners often talk about 'being' (therapeutic, phenomenological, helpful, etc.) that is, espousing existential-phenomenological values and contrastingly, the primary care model is constructed more in terms of 'doing' that is,

in terms of the function and outcome that the constituent parts of a particular intervention are intended to have.

Certainly, it was my experience that once I started to veer away from attempting to look for parts, elements and categories and started to look at processes and relationships between different accounts, the analysis became more fluent. However, despite this there remained a tension between the creation of a ‘theory’ and the idiosyncrasy of EP practice, especially where my own desire for conceptual clarity stood in tension with the ‘messiness’ of context-dependant therapeutic work.

Therefore, drawing out overarching themes while honouring practitioners deep commitment to practicing in an idiosyncratic, individualised, client-focussed way formed a major aspect of constructing this category.

5.4. Negotiating Practice in Primary Care

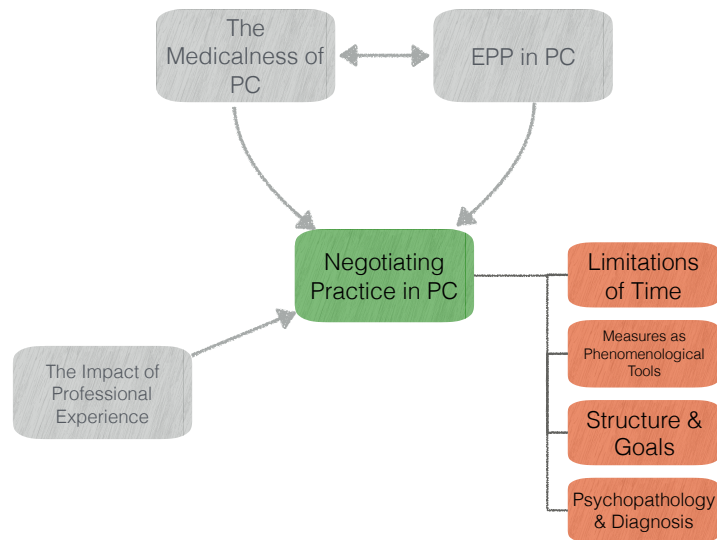


Fig 6: Negotiation Practice in Primary Care

As outlined in the previous two categories, the demands that the ‘medicalness’ of the primary care milieu makes on existential-phenomenological practitioners and practices results in EPP as being experienced as not *ready-to-hand* (Heidegger 2006) and practitioners experience themselves as Other within the primary care context. Therefore, the practice of EPP in primary care is dominated by tensions and practice dilemmas. In fact, at the start of their work in primary care, many of the interviewed clinicians remember being sceptical as to whether they would be able to find a fit between EPP and the medical model. However, rather than eschewing or ignoring this tension, all practitioners in this study describe entering into a dialogue and negotiation that aims to narrow the gap between EPP and the primary care context. This present a major aspect of the grounded theory put forward by this study.

The following category describes a process, which is best described as the process of learning to work in primary care. Subsequent to a general outline, the four most salient practice dilemmas and the ways practitioners manage them are addressed in turn: managing the limitation of time, working with goals and outcomes, using psychometric measures and working with diagnosis and pathology. Approximately 35 percent of the overall data are coded within these subcategories (ranging from 20 to 50 percent of individual interviews).

Recognising & Accepting Givens

In general, most practitioners voice positive experiences of working in primary care and many would consider continuing to work in this setup, although only one of the interviewed practitioners currently works in primary care. However, at least initially, many of the interviewed clinicians are sceptical whether they would be able to successfully practice in this setting. Particularly those who start working in primary care as part of a placement early on in their training (about a quarter of participants). However, independent of the length of professional experience, all practitioners describe a number of processes of learning, adapting and developing ways to bridge some of the practice dilemmas they face. This is nicely captured in the following extract from the interview with Tony:

One of my reservations beforehand was that you can't do, you can't do anything valuable with someone in such a limited space of time. But actually I think you can, I truly believe you can. (49:33 - 50:04)

Practitioners frequently talk about recognising or acknowledging the potential for tensions between the EPP and the medical model of the primary care setup in their work with clients. They place a great emphasis on making such situations explicit thereby incorporating them into the structure of their therapeutic work. This is described very vividly by Albert, when he talks about working from the office of a GP, which presents a physical setup that is 'medical' in its origin and thereby has the potential to create expectations on behalf of clients that stand in contrast to an existential-phenomenological perspective.

Albert: It can't be sanitised. So there is a sense in which often what I would do is acknowledge within very early on, within the first session as part of the whole sort of the whole sort of paraphernalia [sic] of contracting would be to also highlight, not so that I am drawing attention but that I am opening the possibility of a space for comment for the client that I am aware that we are meeting in a place where you would normally see your GP. And it is likely that we are working quite differently. (13:32 - 14:10)

Significant in this is also to recognise that potentially there is no choice involved, no option to change the nature of the tension or the context in which it arises. In the above extract, Albert alludes to this when he talks about the impossibility to 'sanitise' the context of his work from the influence of the medical model. Other practitioners, like Susanna in the following extract, talk about framing the problematised context in terms of a 'given', that is accepting it as a limitation placed on their practice.

Susanna: Well, it is limited but it's part of the...it is limited in a way, limiting in a way, but at the same time, uh, [3s] well, I guess my [inaudible] was well that's what we have to work with. And it's, it becomes uh, what's the word, a Given. (38:18 - 38:53)

Often practitioners describe momentarily putting tensions 'on hold' by 'bracketing' them. This allows them to explore the personal relevance with regards to the client, rather than staying 'stuck'. While the exploring, laying open and making explicit the personal relevance of disconnects that are experienced by clients and practitioners does not always dissolve

tensions or practice dilemmas, it allows practitioners to engage and work with them. Albert makes reference to the phenomenological method as framework for this:

Albert: So the idea that the person already has, for instance that I might receive something from the GP that suggests a diagnosis if you like or some sort of framework for viewing the client's issues. And there is something about suspending that or bracketing it in a phenomenological sense in order to be able to see and hear and encourage the client to bring what they are bringing from a broader dimension rather than just the medical. (14:28 - 15:19)

Overall, some practitioners reflect that an important aspect of the learning that they achieved in the course of their work in a primary care environment includes the recognition of the universality of tensions to the practice of existential therapy: while some of the tensions practitioners encounter are specific to primary care, the practice of existential-phenomenological psychotherapy involves negotiating tensions irrespective of the setup. Robert summarises this in the following extract:

Robert: You make do with what you're got and you know in the existential approach those are the givens, [...] so I suppose what I am saying is yes there are problems and challenges specific to working within the NHS but wherever you work there are specific problems and challenges to do with the setting. (45:43 - 48:56)

Within this, practitioners describe their work as consisting of de-mystifying implicit clashes and tensions and inquire into their implications collaboratively with clients, without pre-empting a particular solution. Practitioners describe the successful mastery of negotiating tensions as standing at the heart of their practice and as existential values in themselves as Lindsay does in this example:

I think it is about whether you give in to that pressure [of fitting into the NHS] and then, sometimes I have and sometimes I haven't and the times I haven't it felt more, more existential. (24:21 - 25:11)

This is outlined in more detail in the following subsections with reference to four concrete practice dilemmas.

5.4.1. Time & Limitations of Time

One of the prominent aspects of providing EPP in primary care as opposed to other settings, is the brief nature of the work. Practitioners typically deliver between six and ten sessions of psychotherapy. Session numbers are usually not extended, mostly due to service-imposed procedures and the resources available at the initial steps of the NHS stepped care model. Working within limited timeframes provides a dilemma for most of the interviewed practitioners, at least initially. However, as practitioners accept them as a Given, they find ways of adapting their practice to fit within brief timeframes mainly through working in a more 'directive' way. The analysis poses therapy pace, proactive-ness of the therapist, the extent to which clients' meanings are interpreted and openness of exploration as central aspects of working directly with limited-timeframes. Between six

and 40 percent of individual participant's talk is coded for various aspects of time and time-limits with a median of around 20 percent.

Across the data practitioners distinguish markedly between brief and long-term work: while longer-term work can follow what has been termed a more 'purist' or 'traditional' phenomenological outlook in terms of being non-directive and exploratory, brief practice is unanimously constructed as an adaptation to primary care.

Robert [...] if you have the luxury of working with someone for 3 years than maybe you can work in that way. You can work in a very purist manner, but in the short term that's not possible. (15:39 - 15:45)

Initially, the brief time frame is variously experienced as "short", "not free", "not phenomenological" (Natalie, 19:40 - 21:00), "light-weight" therapy (Tony, 26:42 - 27:39) and "a challenge" (Susanna, 1:00:32 - 1:01:06). Half the practitioners talk about feeling under pressure to make the time valuable for clients, carrying the resulting anxiety and frustration as well as adhering to organisational procedures.

Susanna: what's challenging about it? [4s] I think offering something valuable for the client in such a short period. (1:01:20 - 1:02:06)

At the same time, the great majority of practitioners (of varying degrees of experience), explicitly talk about how their initial reservations underwent a shift. This shift is characterised by re-framing the limitation in time, by accepting it as an unchangeable feature, as 'Given' in the setup. Surprisingly, this does not pose an insurmountable barrier or takes away from the EP alignment of practitioners' work.

Natalie: At the beginning, I felt very differently, I felt like oh my gosh I can't work to such short sessions, such short session model, that's not how I want to work, that's not free, that's not phenomenological and then as time went on I just realised that that wasn't true, that that was kind of rubbish. (19:40 - 21:00)

As practitioners gain in experience, they generally conclude that six to 12 sessions are appropriate to the particular client group presenting at primary care level. With the exception of two practitioners, none of the other practitioners talked about increasing or decreasing the number of sessions. However, Tony offers an interesting reflection on the impact of how the offer of a particular number of sessions is framed:

Tony: some were happy to finish at six sessions, others, I wonder whether they stopped at four sessions, rather than taking the six because they felt that six wasn't enough and so they gave up. Whereas had they had in mind that they could have it ongoing, actually six might have been enough. (49:33 - 50:04)

In the light of service demand and waiting times brief therapy is seen as making therapy accessible. Three practitioners made reference to some therapy being preferable to no therapy, particularly the more quickly therapy is made available. Others framed the brief course of therapy as an opportunity for the emergence of a larger and longer process for the client. Two practitioners particularly talk about how shorter-term work shifts the focus from inside the session to in between sessions and beyond therapy. They allude to the

notion that the very limited time spent within session is not necessarily representing the point where clients need to decide on particular changes or come to any conclusions:

Lindsay: [...] it's more helpful in shorter-term work to say: think about this over the next week and then come back and the client says: I've thought about it and this is my outcome. (50:40 - 51:31)

An important outcome of practitioners explicit learning process is that significant moments or idiosyncratic therapeutic processes can be more relevant to the therapeutic outcomes than a certain number of sessions and that therefore treatment length as such is not seen as having an ideal session number. Overall, brief EPP is not construed as less successful than long(er) term psychotherapy.

Alex: And that also got me through, uhm, or helped me get my head around a short model that actually five minutes can be enough. It doesn't have to be 8 sessions to get some value out of a therapeutic encounter. (17:32 - 18:10)

Working Directively

In addition to accepting time-limits as a Given, the main adaptation that allows practitioners to work in a brief fashion is frequently termed as being 'more directive'. On a discursive level 'being directive' is described with a number of terms such as 'assertive', 'interpretative' 'formulating concerns', 'encouraging', 'guide' 'nudge', 'being critical', 'being challenging'. In terms of the process involved in practice, working directly is constituted of three main elements: the pace of therapy, the degree of clinician-directed structure and the focus of the work.

First of all, clinicians describe a faster pace compared to their experience in longer-term settings. This might mean to pick up themes or patterns within client material quicker, questioning clients tentatively about their importance and relevance, rather than leaving them emerge more slowly, and 'sitting with' concerns.

Lindsay: And I think I would make those connections faster in short-term work than I would in long-term work. (33:53 - 34:30)

Secondly, short-term therapy is constructed to put more emphasis on the practitioner to make decisions and to explore their hunches or ideas as soon as they arise. For practitioners a tension manifests in the choice points; to what extent they can follow their clients in their exploration and to what extent they need to direct the process so that it becomes therapeutically helpful, given the limited time available. Practitioners put forward a way of working that is pragmatically or practically oriented in the sense that it is less 'purist':

Robert [...] you have to be quite quick in formulating an approach and I suppose that does create slight tension in between the kind of, you know the kind of traditional phenomenological stance adopted by an existential psychotherapist. (9:34 - 12:34)

Brief EPP is construed as somewhat less phenomenological in the sense of emphasising less the horizontalisation and non-hierarchical exploration of experience but rather aware of the fact that, as one practitioner puts it: “clearly some things are more important than others” (Tony, 21:02 - 23:15). For example, given the limitations of time, practitioners chose on occasions to interpret the client material in accordance with how they understand their clients’ perspective rather than dedicate time to fully explore the meaning that clients ascribe to their concerns:

Natalie: I really try to be real, and present and respond to what I think a client is needing, or you know when I've had, I've had clients sit down and when I've asked whether they ever had therapy before and they said yes but my last therapist didn't speak and that used to drive me crazy and I know some therapist's response to this would be like, ok let's talk about what's difficult for you about being with somebody that doesn't speak whereas my response to that is, well then I speak. (42:22.8 - 43:22)

Robert, for example, outlines an EP way of formulating hypothesis that is based on enquiring into the kind of choices that clients make

Robert: the kind of formulation we would come there would be something along the lines of, you know, what choices have they taken that have lead them to being in this place [...] and then what choices could they take to be somewhere else? Now what would making those choices involve? [...] I think what you are also doing is presenting back to the client. In a more explicit terms, perhaps the kind of existential formulation of the situation that they are in. (17:08 - 18:13)

Finally, working directly in a short-term context means to be more selective about what aspects of the client presentation to work with. Negotiating the therapy focus, including, ‘checking in’ with clients is construed as more proactive and thereby distinct from longer-term work. At the same time, practitioners also often recount a frustration of being presented with a very rich and complex clinical picture and having to neglect certain aspects and emphasis others. In the following abstract, Albert details how he attempts to responsively incorporate client feedback to determine the focus and direction of the therapeutic work:

Albert: I might check out with more questions around is this sort of space of exploration ok for you? Did you want to hear more from me or are you ok using the space that way [...] kind of having some sort of interpretative involvement. By judging whether to ask in this way, are you happy with where things are or whether I might say, look it seems to me that you have all of this going on and that we could really focus on areas that are important for you around conflicts you have or the kinds of things that don't quite fit for you. (45:06 - 46:57)

Overall, working in a brief way requires practitioners to balance interpretations of the client’s subjective experience in order to make effective use of the brief timeframe with the need to remain within the client’s horizon and without “leaping-ahead” (Susanna, 1:03:27). There is some evidence in the data that there is a range of practices on the spectrum from directive-interpretative to more open-ended-phenomenological. Susanna is the only practitioner however who clearly positions herself on a more non-directive end of the spectrum and also likens this to working in longer-term working (her “usual way of working”):

Susanna: Yeah, my first reaction to 6 session was to, to challenge more to leap ahead and almost give the client the, some kind of direction. The answer is somewhere here. Go down that path. Uhm, but it doesn't work [laughs] so in that way, I get back to my usual way of working. (1:02:52- 1:03:27)

However, without verbatim session protocols it is difficult to tie such different perspective to actual practice. It remains somewhat unclear whether these differences are limited to a discursive level, with practitioners ascribing different meaning to the same term, or whether this translates into differences in practice.

5.4.2. Structure & Goals

Throughout the data, the setting of goals for therapy receives relative prominence as a way to establish direction and orientation for the therapeutic process, especially within the brief timeframes available. Coding for this sub-category takes up between five and 30 percent of each interview with a median of around 15 percent. This high percentage of coding was expected to a certain extent, given that goal setting and outcomes were questions in the interview schedule sparked by my own experience of working in primary care: it was my experience of working in primary care that it was often either difficult to establish goals at all or initial goals would change throughout the therapeutic process beyond recognition on one hand, however on the other hand I saw them as an important element to keep my work on track. As a result, it was with an attitude of curiosity on colleagues' perspectives that I embarked on this question. However, even outside of specific questions in the interview schedule and even when specific questions were removed from the interview schedule due to category saturation being reached, most practitioners still thematise the notion of goal setting independently.

Patrick: The way that I work in primary care is also shaped by goal-setting. (23:20 -23:34)

However, goal-setting is also raised as a tension in practitioners' work as it is seen as imposing a rigid structure on the therapy within contrasts with the spirit of EPP. Natalie's account exemplifies this:

Natalie: To be perfectly honest I find goals to be a bit of strange thing in therapy sometimes, because I've never really experienced...I feel like they're quite reductionist and I don't know, I feel like they are hard to measure a lot of the time. (37:10 - 37:33)

Practitioners manage this tension by shifting the therapeutic focus from goals to the process of establishing and re-negotiating goals. Rather than altogether forego the use of goals, or alternatively resign themselves to making use of goals in a rigid, 'un-existential' way, practitioners use goals as a reference point to give direction to their work.

In general, practitioners do not take a lead in establishing a structural frame, i.e. in terms of suggesting specific therapeutic tasks at particular points in therapy, even though one practitioner suggests the first three sessions to be different to the last three sessions. Therefore, therapy structure is mainly based on clients' individual concerns.

About half of the interviewed practitioners talk about establishing a ‘formulation’, ‘hypothesis’ or ‘theory’ about where the client is currently at with their concerns at an early point in the work in order to make effective use of the time available. Some practitioners (4 out of 9) set out goals with the help of the CORE system Goal Attainment form. Throughout the sessions practitioners find themselves referring back to these initial formulations as a way of checking in with the client about the usefulness and progress of the therapy and as a way of establishing and maintaining the client-lead nature of EPP.

Alex: So, as a way of sort of re-establishing expectations in a session it will be about bringing it to the here and now and whether somebody is getting out of the session what they want to achieve. (12:08-13:42)

At the same time, practitioners often problematise that a medical perspective, and therefore frequently also clients, assume there to be a linear progression from setting out initial goals to achieving certain outcomes. In contrast, clinician’s experience of actual practice follows a different model and is frequently less clear and predictable. As Robert says:

[...] you've got a client coming along who is expecting you to tell them what to do, that's not what the existential approach is going to offer. And I think some clients, and again I think the setting contributes to that, expecting to turn up there, in other words almost expect to get written a prescription for getting better, or getting over their problems. (6:09 - 6:57)

Another example of the kind of typical dilemma the practitioners work with is the fact that referred clients frequently arrive with a diagnosis or a circumscribed reason for referral mostly as set out by the referrer (such as a GP). Practitioners find clients often to have expectations to ‘get rid of’ problems, to ‘be told’ how to work towards a ‘solution’ and this is often problematised in practitioners’ accounts as narrowing and limiting the therapeutic work.

Robert: You are not working in the kind of rigid goal oriented way that you would be in a kind of, in a CBT LAPT invention, uhm intervention, uhm you're not, you're not setting off at the start saying: by the end we will achieve this. (22:04 - 23:54)

As with other areas discussed previously, acknowledgment and acceptance presents a reconciliatory aspect in practitioners work: one of the ways of working with clients’ expectations is to spend a proportion of therapy realigning the reason for referral with the client’s own experience. Existential-phenomenological practitioners, like Lindsay in the following example, emphasise the notion of therapeutic goals as a loose framework.

Lindsay: And that's what make existential therapy quite useful because, then they can think about their phenomenology because they can derive their own, there is time to think about their own reason for referral and not believing in absolute truth: this is the reason for referral and this is how we are going to treat it. (10:49 - 11:49)

It is practitioners’ experience that, even though there might be some initial aims and objectives, often in line with the reason for referral given by the referrer, the exploration

of clients' concerns, change the focus of what clients want and their appreciation of their initial presenting concerns. Albert summarises this very succinctly:

Albert: [...] the recovery that they experience may not conform to their goals. (24:51-25:48)

Central to this is a conception that it is not particular goals that carry importance, but rather the process of setting out aims and working with them and particularly the relationship towards this process carries importance. Again, Albert summarises very comprehensively the way in which practitioners across the data work with goals, acknowledging their importance, but at the same time their changing nature.

[...] from an existential perspective is that what I don't have to do is keep tapping the paper with the goals on to say look you are getting off the point. You know I can allow the flexibility I have so long as I am mindful of the structure that was originally set up by the client. I will allow then throughout that period to then say: do you want to refine one of your goals? It seems you started out wanting this but this looks also relevant for you. How do we feel about that? Usually they will do that with some qualitative writing on that CORE goal form. (29:25-30:37)

The aims for brief existential-phenomenological therapeutic work are constructed as not having to be achieved at the end of six or eight weeks, but rather they function as signposts of the direction that clients want to take or have taken, often beyond the particular course of therapy. As Albert says:

My feeling around goals is that that's not where the work begins and finishes. (23:01)

5.4.3. Measures as Phenomenological Tools

All of the interviewed practitioners report being required by their service to use a variety of psychological measures and assessment tools such as the PHQ-9 depression scale, the GAD-7 anxiety scale, the social adjustment scale or CORE system of outcome measure. The use of such measures presents practitioners with a dilemma as they uniformly see the use of psychometric measures to establish psychopathology, to benchmark performance and client progress as antithetic to EPP, at least initially. Accounts on psychometric measures are also often linked to the notion of outcomes, which provides a further tension for practitioners. In the end, most practitioners put forward a way of working that is attempting to reconcile these tensions. Overall, practitioners' accounts suggests that measuring therapy does not necessarily have an adverse impact on the therapeutic relationship, even though it might not be therapists' preferred way of working.

Between one and eight percent of participants' accounts are coded in this sub-category. The emergence of this theme is not surprising, especially given that at least the first version of the interview schedule enquired into the use of psychometric measures, however the manner in which practitioners thematise the way in which they negotiate their own practice is not preempted in interview questions. Markedly, within this themes, there is no systematic difference between the accounts of less experienced practitioners and more experienced practitioners, and between practitioners working in primary care as part of their training as opposed to post-qualification.

The ubiquitousness of the influence of psychometric measures is framed succinctly by Patrick:

Patrick: You know, for example the language of the GAD-7 and the PHQ-9 and the phobia scale, and the LAPT data set and the language of the CORE and the way it shapes the focus of the sessions. (10:52 - 12:48)

Often, the contentious nature of using psychometric measures from an existential-phenomenological perspective already becomes apparent in the rhetorical construction of them as ‘forms’ or ‘questionnaires’ which carried a somewhat negative connotation thought the data.

Alex: Before I started there I absolutely detested forms. (43:02 - 43:55)

Using psychometric measures is mainly problematised in two ways: first of all, measuring therapeutic progress is frequently criticised as reducing clients to numbers and disregard the holistic perspective practitioners take on their clients. Secondly, measures and questionnaires are seen as establishing an external structure to the therapeutic session (and therefore on clients’ experience) which is perceived as outside imposition: filling in measures takes valuable in-session time and compromises the therapists independence from the medical model.

However, the majority of practitioners experience a shift in their experience. Annika, for example talks about finding a ‘middle ground’ between scepticism and usefulness (8:02-10:49).

In the beginning they were an inconvenience. I didn't know to make this business of scores and outcomes and quantifiable results, uhm feel organic in my work. [...] but I think once I was a bit more open to the idea of graphing somebodies results over a period of eight weeks, uhm it was actually useful. Because you can use it as a therapeutic tool. (39:57 - 42:22)

Practitioners talk about suspending their disbelief and accepting them as ‘Given’ in the context of primary care. Some practitioners report that having initially asked clients to fill in the questionnaires before coming to the therapeutic sessions they made the process of filling them in part of the sessions as their experience in primary care grew.

Natalie: So, I started off asking them to do them in the sessions.[...] and I'd always say: "people have different responses to these forms, please tell me what it like for you to be filling them in". (8:02 - 10:49)

This way of working is often termed as being ‘phenomenological’ in the sense that practitioners enquire into the phenomena at hand, that is, the relevance of particular measures to the individual client-therapist context.

Lindsay: I did find it useful because I used it as a phenomenological tool. (43:51 - 44:01)

Practitioners talk about integrating psychometric measures, collaboratively with clients into the therapeutic work where they have previously seen as separate from it, part of the

administrative requirement of primary care. As a result, ‘forms’ are used as a way to determine the focus of their work.

Lindsay: While we are speaking I am thinking the whole time of, of the universe, very helpful (laughs) [inaudible], just the blackness of it and then using the PHQ-9, I just take the stars that we can see and we connect them in a way that the client wants to connect them and then that just positions us somewhere in this vastness. So, I find it really helpful. (44:06 - 44:46)

While it is acknowledged that this way of working is not useful for the therapy with every single client, as some clients might find forms frustrating, reductive or simply not applicable to their concerns, there is a consensus among practitioners there is a potential relevance to their work which allows them to incorporate them into their practice. Patrick describes the process of changing his attitude in rich detail:

Well, I think, well I think at the beginning I remained fairly idealistic about [...], for example the GAD-7 and the PHQ-9, I have noticed that the way in which I engage with that particular piece of technology has changed quite a lot over the time. [...] it kinda feels that I, that I was, I might have been avoidant of the, of the imposition somehow. Tried to not respond to it. For example, so I would give the client the PHQ-9 and the GAD-7 but for a long time, I would try and get them to fill it in beforehand. And not actually, you know, so say anything about their answers at all. It would be like they're handing me a ticket, a blank ticket with nothing on it. I didn't bear it as a communication of any kind. Because I didn't really want to engage with the language, I didn't really wanted to go there. And as time went on, you know, in some ways, of course sometimes you have to use the questions in risk assessing for example. It's quite a sort of, uh, I wanna say useful. (12:51 - 14:37)

At the same time, there is a sense in practitioners' accounts that being able to successfully work with and integrate psychometrics into EPP in this particular setup does not mean that this is their preferred way of working.

Susanna: In fact we were encouraged to embrace this questionnaire and to include that in our work but I never felt quite comfortable in doing that. [...] Unless the client were interested in the questionnaire. (35:41 - 36:05)

To the surprise of some practitioners, individual clients also find evaluating their therapeutic progress with the help of outcome measures useful, challenging their *a priori* assumption as Natalie points out in the following extract.

Natalie: I had one client who loved them, who would remember her scores each week and come back and comment on how interesting it was. (8:02-10:49)

Robert has a notable reflection on the interpretation of psychometric scores as he distinguishes between how these are interpreted traditionally and how they can be interpreted from an existential-phenomenological perspective:

Robert: The nice thing about working with an existential approach [...] is, you can reflect on the fact that actually someone's you know, increasing GAD scores actually might be a sign of something important rather than something negative because if we're reflecting on what's going on for this

client, we'll actually an increase in anxiety might mean increase in the awareness of the possibilities and freedoms that they do have to chose things which before weren't there. (9:34 - 12:34)

Therapeutic Outcomes

In practitioners' accounts the notion of using psychometric tools is often related to the notion of therapeutic outcomes: that is the kinds of resolutions that clients find as a result of therapy. There is a (mainly implicit) sense that both the terminology and the notion underlying the concept of 'therapeutic outcomes' presents a tension for existential-phenomenological practitioners: on one hand, practitioners put forward a wide range of examples how therapy is useful, helpful or meaningful across several clients: this includes gaining clarity, getting in touch with their own experiences, discovering their own voice, validating their own experience, feeling safe to articulate their concerns, exploring feelings, thoughts and assumption, being held and contained through therapy, understanding better their motivations and concerns, achieving goals, as well as managing and containing anxiety. Sometimes this also includes a decrease in the scores of psychometric measures, especially if this is of importance to individual clients:

Natalie: And I had a couple of clients who asked me to bring the summary of their scores to our last session so they could see them which I did and then we talked about what they meant and what they felt about them. (37:52 - 38:49)

However, at the same time when practitioners talk about the outcomes of their therapeutic work, they stay at the level of the specific context or specific client and practitioners do not tend to generalise beyond such particular encounters towards the more general types of outcomes which EPP might elicit. Indeed, practitioners generally do not accept the validity of universal rather than particular therapeutic outcomes or indeed the validity of psychometric measures to captures such outcomes. The following extract from the interview with Albert exemplifies this:

Albert: And from that we open up a little bit more what the experience of doing or not doing is. Because otherwise it feels for me as though I am giving the client a strong indication that there is particular thing and a place that they need to get to in order to move closer to their goals. (34:45 - 36:14)

There is a sense in some of the interviews that practitioners themselves are ambivalent about the usefulness of emphasising certain types of more generally defined outcomes, aims and therapeutic goals that describe EPP beyond individual therapeutic encounters. Often the context of such accounts is linked to practitioners' attempts to make their work intelligible, either to clients or other professionals and indirectly also possibly myself as the interviewer. Therefore, when practitioners seem to search for ways in which they can talk about and articulate their practice in a way that encapsulates not only particular examples but gives a broader sense of the what and how of their work this is less because it seems important to their practice with clients but rather it is more directed at outsiders, and serves as a way of emphasising the value and utility of the therapeutic practice.

Robert: [...] if we are to measure ourselves in terms of the kind of the same performance scales as the kind of the LAPT CBT interventions we are achieving similar if not slightly better results over the same period of time. So, I think we can justify ourselves in terms of that kind of research. (41:57 - 43:30)

5.4.4. Psychopathology & Diagnosis

Access and referral procedures of the services where interviewed practitioners work often draw on psychopathological notions to classify clients and determine treatments. The use of diagnostic categories and labels pertaining to the diagnostic manuals such as the DSM or the ICD emerges in the data as a rupture line between primary care and existential-phenomenological philosophy. However, practitioners also learn to incorporate working with diagnostic labels into their work. Between one and 22 percent² of individual practitioners' accounts with a median percentage of about three percent are coded talk about diagnostic categories and pathology. Markedly, there is no systematic difference in the content or nature of accounts of less experienced practitioners compared to more experienced practitioners or between psychotherapists and counselling psychology trainees.

Practitioners often problematise the use of diagnostic categories and labels. Mainly four reasons for this emerged from their accounts: first of all it is practitioners experience that diagnosis create expectations on behalf of both clients and other professionals to do therapy in a particular way and secondly, closes down potential explorations of issues outside of the remit of the specific diagnostic label. Thirdly, diagnoses such as anxiety are seen a problematising inevitable aspects of human existence. Finally, diagnostic labels, according to the interviewed practitioners, do not present predictors of clients' suitability for EPP and neither are they predictors for therapeutic outcomes. Rather, practitioners across the data feel that their way of working is useful for the majority of the clients that they are referred. As a result, no practitioner reports applying psychiatric classifications based on a diagnostic manual in their practice and throughout the data there appears to be a consensus that this would not form part of EPP. Natalie and Tony capture this succinctly in the following extracts:

Natalie: [...] but something about not being like: right you are here for grief therapy because your dad's died. That can be really helpful, because really the grief for her dad was being experienced as being connected to lots of other stuff. (29:37-30:01)

Tony: So, for instance someone suffering from anxiety as diagnoses by the GP would maybe feel that there is maybe some strategies and techniques, umm that can be put in place, that can eliminate anxiety whereas from an existential perspective anxiety is seen as a part of the human experience. (36:48-38:23)

² The large variance is mainly due to one practitioner, who emphasises his stance on pathology more than others throughout the interview.

On the other hand, practitioners find diagnosis and diagnostic terminology to be an intrinsic part of the primary care environment, as Annika alludes to in the following extract.

Annika: We did work with diagnosis in primary care trust even though that is not necessarily something we work with as an existential phenomenologist. (8:42 - 9:43)

Depending on the referral procedures of services, interviewed practitioners are expected to work with clients that carry a wide range of diagnostic labels such as Depression, Anxiety, Claustrophobia, Agoraphobia, Obsessive Compulsive Disorder, Post-traumatic Stress and even Psychosis.

Patrick: I always remember this client, who would clearly meet the criteria for an OCD diagnosis [...]. (24:48 - 26:24)

Practitioners are therefore presented with a practice dilemma which they allude to in a variety of accounts: on one side they resist the use of diagnostic categories for their clinical work, on the other side, these labels enable clients access therapy in the first place. Overall, the way in which practitioners manage this tension is often framed as a learning process that follows the already outlined process of acceptance and bracketing. Albert describes this as follows:

Albert: So the idea that the person already has, for instance that I might receive something from the GP that suggests a diagnosis if you like or some sort of framework for viewing the client's issues. And there is something about suspending that or bracketing it in a phenomenological sense in order to be able to see and hear and encourage the client to bring what they are bringing from a broader dimension rather than just the medical. (14:28 - 15:19)

Practitioners describe the diagnosis that clients 'bring with them' either from their GP, a previous psychotherapy or from an initial assessment frequently as the starting point for their work. Most practitioners mention that they value taking some time to understand the diagnosis of a client as a label with them and try and uncover what that means for them as a person.

Lindsay: I found it [EPP] helpful when somebody's reason for referral was depression or anxiety which was the majority of the cases, but it allowed us to unpack that. And somebody, and, I think also clients found that useful to not think: I have got a mental health issue but rather what does this say about me as a person? (38:23 - 38:49)

At the same time, several practitioners talk about challenging the assumptions that might be attached to certain diagnosis especially that of being vulnerable or dysfunctional. Indeed, much of the work that practitioners describe is focussed on unearthing these fundamental or 'sedimented' meanings and exploring with clients to what extent they are able to evaluate them or dispense with them.

Albert: [...] I will not imply vulnerability that isn't there in the client [...] And I am constantly reminded that you got here somehow through a world using the means that allows you to get here and committed to doing that and you are going to leave here and you are going to re-enter whatever life you are in until we meet next. So, you are vulnerable, there are vulnerabilities but you are not a dysfunctional person. (57:33 - 59:09)

5.5. The Impact of Professional Experience

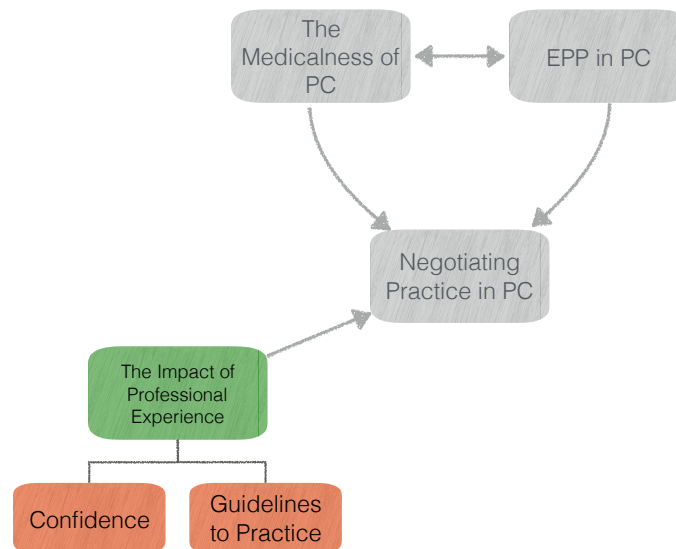


Fig 7: The Impact of Professional Experience

The final category describes the impact of professional experience on EPP in primary care. Specifically, the experience of being in professional training while practicing in primary care emerged as a theme within practitioners' accounts. The majority of the interviewed practitioners worked in primary care as part of their training and being in training features variously throughout the interviews. Therefore, I decided to describe this in a separate category. Analytically, the aim is to draw out similarities and differences between less and more experienced practitioners. As a result, two separate themes emerged: confidence as an important aspect of working existential-phenomenologically and the potential value of a more concrete formulation of EPP at primary care level.

Seven out of nine practitioners had in-training experience of primary care, which ranged from working in primary care as a first training placement (2 practitioners) to working in primary care towards the end of their training (3 practitioners). Being in training features variously throughout the accounts of practitioners, averaging about nine percent of practitioners' accounts. Particularly, trainees that worked in primary care as part of a placement early in their training make reference to a process of learning and gaining experience. Throughout the focus group interview a number of practitioners made reference seeing themselves as more experienced now as opposed to when they first started working in primary care and that the time gap between the individual interview and the focus group have them the necessary distance to consider this.

Overall, the tensions that trainees are presented with are similar to those that more experienced practitioners face: firstly, trainees experience a need to assert the *otherness* of their EPP in the face of a pressure to ‘fit in’ with primary care. Secondly, trainees learn to manage the tensions between the demands of the medical model and their EPP roots.

5.5.1. Confidence

Negotiating these tensions often results in anxieties, doubts and questioning of the value of their work and successfully doing so requires a “solid sense of practitioner identity” (Natalie, 49:33-50:39) and the development of ‘confidence’.

Natalie: I remember talking to my supervisor [...] before I started about how anxious I was about these forms because I didn't know how to [pause] sort of, I wanted to work phenomenologically, and I wanted to transmit a feeling that I was, that I am interested in that kind of, the phenomenological kind of unknowing curiosity. (8:02 - 10:49)

Confidence appears as the main way in which practitioners delineate their identities as trainees from being qualified or more experienced. Confidence is linked variously to being able to provide proactive interventions to clients and being able to judge the level of interpretation of clients experiences appropriately, particularly in relation to the limits in time and therefore the necessity to make choices about the material to be covered in therapy. Some practitioners use the term ‘critical’ in order to describe what they at times opposed to ‘sitting back’ or ‘just listening’.

Annika: I was initially wanting to sit back, I was wanting to sit back and be there in an empathic way rather than moving between an empathic way and a critical way. (22:09 - 24:48)

Confidence is also linked to being valued for their work. As Susanna outlines in the following extract, trainees at times struggled with their validate their emerging identity as existential-phenomenological practitioners against the dominant culture in primary care.

Susanna: I'd say what was difficult about being a trainee that you go in a setting where, so it's LAPT, it was the NICE guidelines and they were encouraging CBT and that's you, you go in a setting where your modality is not really valued I guess. (28:00 - 29:17)

Confidence is constructed as the result of gaining experience within primary care and it is framed less as based on holding a kind of theoretical or practical knowledge but rather to have a sense to trust and reliance being in touch with one's identity as a practitioner. As Albert says:

Albert: So, I think there is something about losing the potential to feel as though there is guidance to be had by seeking too closely some kind of modality, orientation technique based approach. (1:12:20 - 1:14:34)

While growing confidence is associated with feeling less like having to defend or justify their existential-phenomenological stance in primary care, *otherness* continues to be an important aspect of practitioners' identity, irrespective of the length of their professional

experience as Susanna and Tony as less and more experienced therapists, respectively point out:

Susanna: Particularly, the feeling of maybe defending a bit my modality. Or trying to fit in. I'd be much more relaxed about that (FG, 3:20.8 - 3:53)

Tony: So, I was aware of the fact that we were a minority claiming this ground or whatever it is. (6:17.7 - 6:54)

Notably, talk about confidence and the use of overtly emotive language in this context, such as the direct reference to emotions and feelings such 'anxious', 'feeling safe', 'being unsure', as well as the concept of 'learning' is less present in male practitioners' accounts than female practitioners' accounts. Emotionally significant experiences appear more implicit in male practitioners talk. Female practitioners show more of a tendency to engage with their status of being trainees and have a tendency to talk more about supervision. This might be related to the dynamic between myself as a male interviewer and female participants, and adopted or enacted gender roles. However, given the small size of this phenomena and the fact that male participants in general tended to be more experienced I decided make this theme transparent but not enquire further into it.

Overall, while trainees grapple to a greater extent with how to successfully bring together an existential-phenomenological perspective with the reality of primary care, none of the trainees question, implicitly or explicitly their commitment to EPP. Rather, all interviewed trainees express their experience of its usefulness and helpfulness to their clients. Surprisingly, trainee practitioners do not relate being in-training to important changes in the way they work existentially-phenomenologically, rather to a heightened sensibility to the tensions they experience.

Susanna: Would it be very different [if she wasn't a trainee]? [3s] Uhm, probably not actually, I would still work existentially but more confidently, yes. (24:54 - 25:14)

This certainly deviates from my own experience as trainee practitioner in primary care where I felt at times at odds with EPP. However, practitioners do not seem to experience a clear demarcation between being in training, being qualified or being less experienced and more experienced. Rather, they experience learning as a relative spectrum without defining stages or set points. Lindsay, looking back over her in-training experience, makes references to this theme in the following extract:

Lindsay: But I also sometimes think is that expectation just something that I think there should be, being a trainee hoping that I will qualify and then I will have it all. And that's not the case at all. (33:03 - 33:37)

5.5.2. Freedom and Uncertainty: Guidelines to Practice

The extent to which EPP provides practitioners with a large degree of freedom to work with their subjective experience however is at times problematised by practitioners and particularly trainees. This theme is quite subtle in the data, most practitioners only allude to it once throughout their accounts. When they do, they articulate that choice about how

to work existential-phenomenologically gives rise to various degrees of anxiety and provides practitioners with challenges as to their own role as facilitator of therapeutic change, particularly in the urgency of time-limited contexts. This is especially the case when practitioners are unsure about how to respond to clients or how to understand their clients' perspectives. Several practitioners talk about how they negotiate the 'vastness' (Lindsay) of possible ways of approaching client concerns and the subjective philosophy EPP contrasts to the kinds of more structured or 'concrete' (Annika) narratives of being a professional in a context which requires clearly reasoned responses and decisions.

Lindsay: Intrinsically, I would like to say: no I am fine with the vastness and freeness of this because I like the scope, like we said before, I like the scope of what we can cover but I think as a professional I would like to be able to say: this is what I do and this is how long it takes. (27:31 - 28:10)

Five trainees also make reference to a lack of guidance specifically on brief EPP in primary care:

Patrick: I think that short-term work presents a more complicated ethic, particularly in the NHS, than the kind of existential training prepared me for. (28:50 - 29:57)

Three trainee practitioners describe having searched for literature and advice to guide their practice when starting their placements. When I enquired into this in more details, these practitioners also talked about potentially finding validation of their practice and containment of anxieties in a clearer formulation of EPP in terms of a more systematic model, structured guidelines, or frameworks, both to support them in their work, but also to help them to validate, defend and justify their position within the primary care context.

Natalie: So if there was a way to sort of create a model to sort that validated the relationship, freedom and working phenol...how you can work in a setting that is very medical in a more phenomenological way than I might think that could probably be helpful particularly for trainees cause it takes a while to figure it out by yourself and just being sort of championed or validated in that. (46:03 - 47:09)

The concrete shape of such a model is uniformly construed to contain general principles of working existential-phenomenologically and the outline of possible conflicts when working in primary care. Further, participants felt it useful to have outlines of areas that form an important aspect of this kind of work, such as a more concise definition and outline of EPP at primary care level to help communication with other professionals and stakeholders, guidelines on conducting initial client assessments, guidelines on working with time-limits, guidelines on formulating client concerns early on in therapy and more general frameworks that emphasise the importance of supervision and peer supervision. At the same time trainee practitioners are concerned with maintaining the freedom to work in an individual manner with each client and reject the notion of working to a pre-defined structure. One practitioner in particular rejects the notion of 'being told' (Alex, 18:16 - 20:03) how to work which he links to the risk of moving focus away from clients' experiences.

Lindsay: The manual shouldn't contradict the work you are doing. But I think having some principles would be helpful. (57:55 - 58:40)

5.6. Member Check

The feedback from the follow-up focus group and two follow-up individual interviews is largely integrated within the grounded theory. As a validity check, it is deemed to form an integral part of the overall theory, rather than a separate part. The analysis of this data (both the recorded interview as well as the annotated feedback from the copy summary of the analysis) helped me to revisit the emerging grounded theory in its entirety.

Overall, the emerging theory showed a very good fit with participants' experiences, both in terms of the content but also in terms of the comprehensiveness with which it describes the practice of existential therapy within the primary care context and the ways in which practitioners negotiate the tensions and dilemmas that arise for them. Similarly to Alex, who talks about recognising himself in the emerging grounded theory, all of the interviewed participants felt that this theory corresponds to their experience.

Alex: I don't recognise all of it as my experience but I could easily imagine that it could have happened and none of it feels like there is no way that that could have happened. But just some of it didn't happen to me. (FG, 05:05-05:37)

Therefore, on a content level, that is concerning the kinds of topics and themes included into the final theory, only relatively minor changes and amendments were made as a result of the member check. These are made explicit in the text. Instances where the participant feedback significantly diverges from the preceding analysis are also noted. For example, in the second category ('EPP in Primary Care'), the way in which practitioners integrate practices that might originate outside of the existential-phenomenological tradition was clarified by the validity check.

These amendments resulted in some changes on a structural level, especially in the 'flow' within categories, as the feedback highlighted instances where formulations and text structure were ambivalent. For example, the way in which female participants' use of overtly emotional language is described was clarified.

Most importantly, in regards to the analytic-interpretative process, the member check supported my interpretative perspective and the concrete interpretative decisions made throughout the construction of the present theory. Albert sums this up concisely:

I think there are maybe ways in which, which is clear from the focus group in which we could continue to engage with the process of making meaning about the experience of being in primary care and lots of different ways in which we can sort of draw fresh narratives around that, but didn't feel like there were any glaring omissions. (FG, 1:05:55 - 1:06:23)

However, at the same time, the validity feedback from participants encouraged me to revisit the 'depth' of the interpretative analysis that is, the extent to which the analysis of the data moves from description to interpretation. In conjunction with research supervision and a renewed engagement with the aim of grounded theory to provide theoretical abstraction (Corbin & Strauss, 2007), I reviewed and further sharpened the

theoretical-interpretative claims of the present theory, beyond the summary of the analysis that was given to participants. Especially, the first two categories underwent a reorganisation in order to highlight the relationship between the environment in which participants are situated and their responses to this as well as the way in which participants construe their practice as a result. This included at times clarifying the discursive function of participants' accounts.

Moreover, conducting the member check especially highlighted the temporal and contextual *situatedness* of practitioners' experiences and therefore necessarily that of the analysis: some participants notes how their perspectives had changed since working in primary care and since participating in the individual interview.

Lindsay: When we had the interview, when I worked in primary care, the time we had the interview and the time to now, I think there has been quite a lot of professional growth and development, both positive and negative that has changed my views and experiences. (FG, 46:19 - 46:56)

Some practitioners who were in training while working in primary care noted how their identity had changed since as they now see themselves less exclusively wedded to existential-phenomenological traditions and more pluralistically-integrative. Participants' levels of confidence in their practice also changed since being in training and this was incorporated into category 4 which discusses the impact of professional experience.

The final version of the resulting theory is discussed in relation to existing literature and bodies of knowledge in the following chapter.

6. DISCUSSION

The previous chapter put forward a theory of how practitioners construe the practice of EPP in the setting of primary care. This theory was constructed on the basis of an enquiry into the experiences of nine practitioners using grounded theory methodology. In summary, EPP is described as both model and highly idiosyncratic set of practices that, at times, stand in contrast to the medical model underlying the primary care setting. The processes of practice negotiation were outlined that allow practitioners to practice within primary care, including the impact of professional experience.

The findings of this research are especially relevant for the community of existential practitioners but also provide some implications for the field of counselling psychology.

The current chapter places the outlined grounded theory into the wider context, first methodologically in terms of the strengths and limitations of the study, thereafter in terms of its content by discussing its categories and themes in the light of existing literature.

6.1. Strengths & Limitations

To the author's knowledge, the current study is one of only two research inquiries into existential-phenomenological practice in primary care and the only research aiming at elucidating the experience of practitioners within this context.

Therefore, the main strength of the present study is to provide important and novel information on the perspectives of clinicians working in this environment. Hence, the thrust of this research is directed towards the community of existential practitioners maybe more so than other stakeholders such as policy makers, service commissioners or service managers. However, emancipating practitioners within the existential community might encourage more practitioners to enter the primary care environment or take an interest in it as well as stimulating thinking and research that eventually might make policy or commissioning recommendations.

The theory put forward in this research suggests that practitioners are largely successful at negotiating the tensions that they are presented with in primary care, thereby showing that working from an existential-phenomenological perspective is indeed possible in this setting.

Further, the theory that is put forward on the basis of the data analysis not only summarises prevalent themes common to the practice of EPP in primary care but also provides some insight into the concrete strategies and theories-in-use (Schön, 1995) that practitioners employ while negotiating tensions, practice dilemmas and expectations.

Indeed, the present study is the first study that explicitly focuses on the context and environment in which EPP takes place and explores the interaction between clinical practice and context. This is a relevant addition to existing models of EPP such as those proposed by Strasser and Strasser (1997), Langdrige (2006) and Rayner and Vitali (2015) as it provides a practice-based knowledge of adapting EPP in accordance with its practice context.

As a result, the theory put forward in this study makes a contribution to the empirical basis of EPP and provides both some encouragement of the potential applicability in primary care and a foundation on which further research might be based. Further contributions of this study are discussed in detail and alongside the findings in the various sections of this chapter.

In terms of its limitations, the fact that there is little to no previous information about the breath and scope of the researched phenomena makes assessing the potential limitations of this study a difficult enterprise. At the same time there are a number of aspects that have the potential to limit the conclusion that can be drawn from the current study. In order to put the discussion of the strengths and detailed findings in context and allow for the reader's own evaluation, these are discussed first.

Limitations of the Design & Methodology

As Willig (2008) points out, methodologically the use of Grounded Theory in psychological research has been criticised on two accounts: first of all grounded theory has been criticised for paying insufficient attention to contextual validity of results due to its heritage within an positivist-inductive framework. Secondly, Grounded Theory has been criticised for its preoccupation with uncovering social processes which limits its application to questions around the nature of experiences. These criticisms are addressed in turn.

Firstly, as a result of the constructionist acknowledgement of the situatedness of this research, the applicability of the findings have indeed certain limitations especially concerned the generalisability beyond the particular context of this research i.e., beyond the *milieu* that this research, my own participation as researcher and the nine interviewed practitioners created. However, as has been pointed out throughout this report, rather than providing definitive and generalisable statements, the main intention of this research is to give pointers, establish the basis for further enquiries and hypothesis for practitioners and researchers. Such an exploratory stance is particularly appropriate in the light of the relative immaturity of the research field where, as has been outlined in the review of the literature, more unconditional statements are some way off. Further, as outlines in the methodology chapter, particular attention has been paid to the contextual nature of this research, especially the ways in which the researcher impacts on the research and a separate section concerned with the author's response to the research findings (see below) is given. In this way, researchers and practitioners who are intent on applying some of the present findings to related fields are in a position to come to their own conclusions about the suitability and likely success of such an endeavour. Overall, the use of

Grounded Theory for this project aims at theoretical transferability rather than generalisability.

Secondly, with regards Grounded Theory's focus on social processes, rather than individual experiences, the current research is indeed primarily concerned with the reality of existential-phenomenological psychotherapy in terms of how this practice is the negotiated in the context of primary care. It is less concerned with "capturing the meanings that a particular experience holds for an individual" (Willig, 2008, p. 239). While this research includes an investigation into participants' individual experiences this is not where the focus of the current research lies (as outlined in the methodology section) and therefore on a methodological level the above critique appears not applicable to this particular project.

However, on the level of the particular findings, the focus on the process of negotiating practice might be a limitation to the extent that practitioners' selves (see theme *Therapist-as-Self*) are found indeed to be strongly linked to their practice. Therefore, aspects such as individual identity are likely to impact on the negotiation that takes place in the primary care context. This is also relevant in the light of findings such as those put forward by Norcross (2011) who argues for the importance of individual therapists' contributions to the therapeutic process as opposed to the contribution of their theoretical orientation. As a result, the findings of the current research would benefit from additional triangulation with research on therapist's contributions to existential practice, for example research of a more phenomenological nature.

Limitations Stemming from the Employed Procedure

Further to methodological and design limitations, the particular procedures employed also have the potential to limit the findings of this enquiry.

The degree of freedom offered by the use of semi-structured interviews as opposed to more structured forms of inquiry resulted, at times, in shifts of emphasis away from the original research questions towards material generated by practitioners. For example, the impact of the extent of practitioners' professional experience on the research only emerged throughout the later stages of data collection. However, this was reflected on throughout the research supervision process and instances of this were discussed in detail in order to determine a balance between the focus of the research questions on one hand and participants' voices on the other. In fact, the change of research methodology from Thematic Analysis to Grounded Theory, as a more flexible methodology, was partly a recognition of the contribution of participants to the orientation of the final research.

Further, the way in which the sample for the current study was created has a potentially limiting impact on the claims based on the findings of this research. Firstly, the sample size for Grounded Theory studies is somewhat of a bone of contention (Guest et al., 2006), and the sample size (nine participants) of the current study is situated towards the lower end of the recommended spectrum (Ibid). However as has already been argued in the methodology section of this research, due to the high cultural competency of the

participants, that is their expertise within the field they are interviewed on, it can be argued that a smaller number of participants suffices. Indeed, the analysis of the collected data shows saturation for most themes and categories around the fifth and sixth interview. Beyond this, further three interviews were conducted to provide a confident confirmation of saturation which was indeed achieved. Although new themes emerged in the analytic process from later interviews, the content of these can be tracked and found in earlier interviews, too and therefore the emergence of these new categories and subcategories are attributable to the developing analytic process rather than presenting new data.

Secondly, the fact that all participants trained at only two universities within London may have impacted on the findings inasmuch as participants might have had a shared perspective on EPP. However, on the other hand, the two universities involved are the largest existential-phenomenological training programmes in the UK (Correia et al., 2014) and therefore form a representative background for EPP in the UK.

Thirdly, the participant recruitment process of the current study resulted in somewhat skewed sample: more than half of the participants are novice practitioners who gained their primary care experience as part of their training. While it was always the aim to recruit a diverse sample (see methodology chapter) the imbalance towards novice practitioners was partly due to constraints in time and the accessibility of the sample. Indeed, a number of the identified processes in the proposed Grounded Theory around identity formation can be attributed to the fact that some of the participants are early in their career. The process of validating the findings through a focus group also identified further that practitioners experienced their professional learning and development process as impacting on their experiences. This is in line with larger scale research on practitioner development, i.e. Ronnestad and Skovholt (2013) identify differentiated processes in different phases of psychotherapy practitioner development. For this reason, caution will need to be applied when attempting to transfer the findings to contexts where practitioners have established identities.

On the other hand, throughout the analysis and theory generation phase of this research, efforts have been made to differentiate between processes that were experienced by trainee practitioners, those that were experienced by established practitioners, and those that were experienced by all practitioners. In addition, both the analysis as well as the subsequent validity check do not support a theory that puts forward different degrees of professional experience to result in different practice. Rather, differences in professional experience seem to result in different degrees to which practitioners are aware of practice tensions and dilemmas and the need to negotiate these, which is congruent with the literature (Ronnestad & Skovholt, 2013).

On the contrary, the lack of tacit (rather than explicit) skill that novice practitioners might display (Margison et al., 2000; Ronnestad & Skovholt, 2013), might actually work in favour of this research as actions, interventions and theories-in-use might be closer to the awareness of novice practitioners and therefore are easier to reflect on. Further, the sample can be considered quite 'pure' with reference to possible extra-existential-phenomenological influences that more experienced practitioners might have acquired as part of their career.

Yet, the conclusions drawn from this research would benefit from triangulation through for example, a widening of the sample in terms of size, diversity and geographical spread as well as the inclusion of experiences of other stakeholders such as clinical supervisors, other professionals working in primary care and, most crucially, clients.

6.2. Findings

Further to the introduction of the main strengths, but also the potential limitations of this study, the following section discusses the findings in more detail. The structure of the discussion largely follows the structure of the analysis chapter in terms of the order in which the distinct categories of the grounded theory are presented.

6.2.1. *The Medicalness of Primary Care*

This section discusses the first category of the proposed grounded theory, 'The Medicalness of Primary Care' with reference to the existing literature and poses the need to contextualise EPP.

Practitioners interviewed for this research practice in a variety of primary care settings, such as GP surgeries, primary care mental health teams, psychotherapy services provided by external providers and IAPT services, thereby mirroring the increasing diversity of primary care over the last decades (Joint Commissioning Panel for Mental Health, 2012). Many of the interviewed practitioners have further experience of either secondary and tertiary care service provision. However, despite the diversity of practitioners' backgrounds and experiences, a common feature is presented in the 'medicalness' of this context: that is the way in which a medical philosophy underlies the procedures and values of primary care and the manner in which the limitations in time, the notion of setting and achieving therapeutic goals, the measurement of therapeutic progress and outcomes through the use of psychometric tests as well as the use of diagnostic categories form part of delivering psychotherapy in primary care.

In the light of the scarcity of research on EPP in primary care, this forms an important finding: it provides an insight, based on real-world practice, into aspects of primary care that are perceived as relevant to and making demands on EPP. Further, the tone and quality of these demands as rigid and imposing as opposed to being flexible and enabling is described. In this, there is a significant overlap with the way in which Rayner and Vitali (2015) describe primary care to be posing limitations in time, demanding an exploration of the concept of pathology and asking for quantitative evidence. On one hand, this is not surprising as four of the therapists interviewed for this research also worked in the service where Rayner and Vitali's research took place (however not as researchers and not all within the same time period). On the other hand, all other participants worked in separate settings and 'medicalness' is construed similarly across all participants of this research. Other EP practitioners practicing in GP surgeries such as those interviewed for Wilkes and Milton's research (2006) similarly describe time-limits in particular but also

other aspects such as the ‘medical structure’ of assessing clients before the start of therapy to make demands on their practice. Therefore, the findings of the current research not only corroborate existing literature, but expand on it by provide a more detailed understanding of primary care as a practice setting for EPP.

It is also interesting to note that the defining features of ‘medicalness’, i.e. the outlined values and procedures as described by practitioners in this research might not only be specific to primary care: for example, time-limits, goal-setting, psychometric measurement and diagnostic categories are also described as impacting on EPP in settings other than primary care, especially those that subscribe to a version of the medical model, such as many NHS services. Authors such as Wilkes and Milton (2006), Barnett (2009), Steel (2010) and Tantam and Kumar (2009) also reference such ‘medical’ features to be relevant to their work, despite being located in different types of NHS services such as intensive care, acute hospital, secondary care psychotherapy services and GP surgeries. Therefore, the findings of the current research might be of relevance beyond the primary care context and to other contexts such as other services within the NHS where EPP is delivered. At the same time, a further enquiry might focus on comparing and contrasting the understanding of what practitioners in the present research have termed ‘the medical model’ with the understanding of practitioners in different contexts.

6.2.1.1.Contextualisation of EPP

As previously outlined in the review of the literature, generally the context in which therapeutic work takes place is acknowledged to form an important part of EPP: for example the worlds or realms that clients are part of (van Deurzen, 2009; van Deurzen, 2012), the physical setup of therapy (Barnett, 2009; Steel, 2010; Tantam & Kumar, 2009; Weixel-Dixon, 2009) and the relationship to others (Stadlen & Stadlen, 2005; Tantam, 2005; van Deurzen & Tantam, 2005). Yet, the existing literature presents mostly anecdotal accounts; enquiries into context are little systematic and mostly linked to particular client-therapist encounters rather than paying attention to phenomena shared within practice contexts. The present study addresses this lack of research within the particular context that primary care presents.

Certainly, the findings of the present research call for a ‘contextualisation’ of EPP: the ‘medicalised’ context of primary care elicits at times strong responses from practitioners: it is framed as imposing and as creating expectations on behalf of clients and is responded to through the use of emotive language. Further, as the analysis of the data shows, it impacts on and shapes EPP in a number of ways. Indeed, what Ronnestad and Skovholt (2013) say about novice professionals, that they increasingly realise the limitations to context-free theoretical models as their practice matures, might also hold true for relatively ‘novice’ modalities, such as EPP: as EPP matures as psychological intervention, it might be increasingly important to consider it in its context.

While a more detailed exploration of the concrete implications of ‘medicalness’ is outlined in the subsequent sections, overall the present research certainly points to the

significance of enquiring into the environment in which EPP takes place in a more systematic way: this might be especially valuable for practitioners in organisational contexts, such as the NHS where there are shared contextual features that have an impact across clinicians and clients. This might support learning and sharing of knowledge beyond the individual therapist-supervisor dyad and therefore beneficial for the community of existential practitioners as a whole.

Beyond being valuable to existential practitioners, the knowledge developed as part of this study might also help to sensitise stakeholders to the way in which practitioners experience their practice context and aspects that practitioners might find helpful or hindering in their practice.

6.2.2. Existential-phenomenological Practice in Primary Care

The second category of the grounded theory, ‘EPP in Primary Care’, describes EPP in primary care in detail. Practitioners frame this practice as both a particular approach to psychotherapy as well as a loosely linked range of practices. This allows practitioners to tailor their work to the particular needs of clients. However, both of these aspects of EPP are contrasted with the values and procedures espoused by the medical model of primary care which results in practitioners’ identity as being ‘Other’ within primary care.

6.2.2.1. Existential-phenomenological Practice as Model

Practitioners in this research often describe their way of working in primary care in terms of an approach that is discursively delineated from other therapeutic modalities, especially CBT on account of its EP basis, its relational perspective and its brief nature. Practitioners subscribe very clearly to the tradition of the British School with its strong phenomenological influence as articulated for example by Spinelli (2003) and its philosophical basis within continental existential philosophy (van Deurzen, 2012). The British School also emphasises the centrality of working relationally and co-producing the structure of the therapeutic sessions. The fact that the interviewed practitioners draw a similar picture of their practice in primary care therefore appears unsurprising, given that all participants trained and practice in London which places them within physical as well as intellectual proximity to the British School (e.g. Cooper, 2003; Correia et al., 2014).

Specifically, practitioners’ positioning of EPP as delineated approach to psychotherapy, their emphasis on the therapeutic relationship as mediator of therapeutic change and the phenomenological method, places them in the vicinity of Strassers’ model of time-limited work (1997). The overlap between both perspectives might provide some practice-based support to the model put forward by Strasser and Strasser in terms of its applicability and correspondence to real-world practice. However, even though Strassers’ model theoretically shows some potential to be transferred to a primary care context, only two explicit reference to this model are made by participants, both of which do not refer to any specific feature of this model, e.g. the ‘wheel of time’. Indeed, practitioners in this

study respond to the time-limits by working in a more directive and goal-oriented way than Strasser and Strasser advocate (see below). Other differences might be corollaries of the situatedness of practitioners' work within primary care: the use of psychometric measures, working with diagnostic criteria and the absence of the possibility to extend the course of therapy form aspects that are not touched on by Strasser and Strasser.

Practitioners' way of working also shows some similarities with Rayner and Vitali's (2013; 2015) model of short-term existential therapy in primary care: while the primary care context and its impact on psychological practice is construed in a similar way to Rayner and Vitali, and while interviewed practitioners also refer to setting goals, working proactively and using psychometric measures, practitioners in this study respond to the primary care context in a more traditionally 'British-existential' fashion: similar to Strasser and Strasser (1997) they prefer to work in a structurally open way, as opposed to the operationalised structure featuring psycho-educative elements and "experimentation with a newly discovered sense of self" (p.3) that Rayner and Vitali suggest. Indeed, practitioners in this study frequently appear somewhat reactive to any form of operationalisation of their work. This raises the question to what extent operationalised models for settings such as primary care are acceptable within the community of existential-phenomenological practitioners, even if such operationalisations remain essentially non-prescriptive such as those offered by Rayner and Vitali. Indeed, while operationalisation or manualisation might support the research endeavour (Rayner & Vitali, 2013) the question is raised whether this necessarily needs to take the form of outlining session structures. The outline of common practice dilemmas and suggestions on managing these, as articulated by this research might present an alternative way of presenting a model of EPP in primary care (c.f. section 'The Impact of Professional Experience'). Indeed, the extent practitioners adhere to such an outline and rate its usefulness might provide a research endeavour contributing to the formulation of a version of EPP that fits both the primary care environment and practitioners' experiences.

6.2.2.2.EPP as Tapestry of Practices

While interviewees frequently talk about their 'approach', as opposed to other therapeutic modalities, there is some evidence in the data that framing EPP in this ways serves the purpose of positioning and defending EPP within the primary care environment and the territory of other psychotherapeutic modalities. This study puts forward that the actual practice of interviewees is better described in terms of a multi-faced integration of existential/phenomenological ideas and concepts, centred around the presentation of the particular client.

This is very much in line with the consensus within the literature that EPP in its British incarnation is not grounded in a clearly circumscribed model. Rather, it includes a vast variety of influences (van Deurzen-Smith, 1997), presenting a "rich tapestry of intersecting therapeutic practices" (Cooper, 2003, p. 1), on the grounds that therapeutic practice needs to be responsive to idiosyncratic client presentations.

The subjective experience and therapists' sense of self play a particularly strong role within this: practitioners in this study find it difficult or even unhelpful to separate their personal self from their existential-phenomenological therapeutic work. Rather, their practice is 'backed-up' by existential-phenomenological theory, concepts or metaphors when fitting with a particular moment in therapy. Beyond this research, this is variously expressed in the literature (Cohn, 1997; van Deurzen, 2012). The importance of the sense of self to therapeutic work is supported by findings put forward by Wilkes and Milton (2006) who find practitioners placing value on 'being themselves' with clients. This is particularly relevant in the light of the attention that concepts such as 'therapeutic responsiveness' have received recently: across therapies, even including those that are more rigorously manualised, individualisation is found to play a fundamental part as individual clinicians' respond to individual clients. Some authors have begun to argue that this might account for a large part of client change (Norcross, 2011). Equally, Mantica (2011) finds that counselling psychologists working in medical settings experience "that their personal lives, their beliefs and natural characteristics do have a strong impact on the way they are as professionals" (p.115). Therefore, the findings of this research are congruent with recent trends in academic research.

Further research might be warranted particularly and in order to uncover in more detail how practitioners negotiate their individual subjective experience in the light of the therapeutic stance they take and the relation in which this may stand to client experience and therapeutic change.

Notably, throughout the interviews very few examples of integrative practices are presented that draw on methods from outside the existential-phenomenological 'core' territory. Neither are there any references throughout the interviews to any of the published existential integrative models such as Langdridge's integration of solution-focussed principles (2006), Nanda's integration of existential-phenomenological therapy and mindfulness (2009) or any of the numerous integrative models and frameworks developed outside the UK (Fegg et al., 2013; Garlan et al., 2010; Kissane et al., 2004; Lee, Robin Cohen, Edgar, Laizner, & Gagnon, 2006b; Maunder & Hunter, 2004; Vos et al., 2007). On one hand, this is congruent with ambivalent stance that certainly British existential practitioners seem to have towards the notion of technique (Cohn, 2002), as there is a certain scepticism in practitioners accounts towards any form of formal, pre-conceived integration of therapeutic methods, tools or techniques divorced from the actual client encounter. On the other hand, it is also somewhat surprising, certainly to the extent that four of the nine interviewed practitioners are training in counselling psychology, which traditionally subscribes to a pluralistic stance (Hemsley, 2013b; Woolfe et al., 2010) which favours integration. This might be an artefact of the lack of opportunity that early career practitioners had to develop their integrative practice. Equally, it might be that interviewees practice integratively but make no reference to this due to not accepting other modalities' unique claims to a particular method, as one practitioner points out. It might also be an artefact of the way in which practitioners selectively responded to the focus of the research questions on EPP as opposed to other practices. However, going by the predominant silence of the existing literature on the topic of integration (Cohn, 1997; Spinelli, 2007; van Deurzen, 2009), it might simply not

be part of the culture of the British existential community to consider the integration of bodies of practices that are not seen to stand clearly within the existential core territory. This remains the case, despite Cooper's recent attempts to open up a dialogue on this via the route of pluralism (Cooper, 2015).

6.2.2.3. Attitude & Integration

Despite the lack of *overt* integration, framing EPP both as delineated model as well as a flexible set of practices, driven by client needs and practitioners' sense of self, clearly presents an attempt to integrate. This becomes visible when practitioners pose an existential-phenomenological 'stance' or 'attitude' which allows for the diverse concepts, ideas and methods from the existential-phenomenological tradition to be integrated. Such an attitude appears fundamental to practicing EPP in primary care as it provides practitioners with the flexibility to respond to the diversity of client needs on a moment-to-moment basis. Yet, practitioners in this study are not very vocal about the nuances of this process, and therefore the conclusions this study can put forward are limited. This is possibly because the 'doing' of the existential-phenomenological attitude might present a tacit, unreflected dimension in practitioners' work. Alternatively, or possibly additionally, working in this way appears an accepted practice for existential practitioners, certainly going by the existing literature within the UK and might therefore remain unarticulated: authors, such as (Craig, 2012) distinguishes between the discipline of psychotherapy and the *démarche* of EPP "as the kind of intention or purpose one brings to a particular learning or practice" (p.8). Equally, Spinelli (2007) talks about an 'existential attitude' that is founded on the recognition of the three principles of relatedness, existential uncertainty and existential anxiety.

Further research might usefully unearth in more detail different aspects and the underlying structure of this attitude, specifically the kinds of theories-in-use (Schön, 1995) practitioners draw on and how they translate these into practice. This might be particularly pertinent, as such an attitude might also allow for an integrative, pluralistic and idiosyncratic practice beyond the territory of traditional EPP, as for example Cooper (2015) raises. Particularly, for counselling psychologists who adopt a pluralistic stance by virtue of their professional regulation (HCPC, 2015) this might be valuable as there is no accepted way of integrating useful or empirically supported methods and tools from other modalities into EPP.

It might also be worth contrasting this to the American humanistic-existential traditions (Norcross, 1987; Schneider, 2008), which feature a remarkable cross-fertilisation and practice the integration of a wide range of concepts from psychoanalysis (Dowling, 2003), cognitive therapy (Kissane et al., 2004; Lee, Robin Cohen, Edgar, Laizner, & Gagnon, 2006b), behaviour therapy (Fegg et al., 2013), attachment theory (Mauder & Hunter, 2004), meditation and relaxation (Vos et al., 2007), narrative approaches (Garlan et al., 2010) cybernetic systems (Anchin, 2003) and psycho-education (Dowling, 2003). Rollo May, for example (1958) talks about the existential therapies as a movement:

The existential therapy movement [...] does not purport to found a new school as over against other schools or to give a new technique of therapy as over against other techniques. It seeks rather, to analyze the structure of human existence (p.7).

Further research might unearth what enables the integrative stance of these approaches and whether this might be translate to EPP.

6.2.2.4. Being Other

The way practitioners frame EPP in primary care as both a model and a set of practices integrated by an existential-phenomenological attitude, appears in line with more recent conceptualisations of existential therapy (World Confederation for Existential Therapy, 2016). Yet, it challenges the conceptualisation of psychological work in terms of clearly delineated ‘modalities’, which traditionally forms the basis of service provision in the NHS (BPS & Department of Health, 2001). Rather, it sides with the way in which increasingly therapeutic models such as Brief Psychodynamic Therapy (Lemma, Target, & Fonagy, 2011b) or Cognitive Analytic Therapy (Clarke, Thomas, & James, 2013) are considered for commissioning in primary care (NIMHE, 2010), that might be based on particular modalities such as psychodynamic psychotherapy, or CBT but are developed integratively and adapted for particular contexts. This also locates practitioners in the post-modern/post-existential territory that Loewenthal postulates (Loewenthal, 2011a) which is “more about the activities in which we participate with our clients/patients” (p. 175) than theoretical models.

Certainly, eschewing a more rigidly circumscribed or ‘operationalisable’ definition of EPP allows practitioners to be flexible in aligning their work in accordance with the individual needs of clients (World Confederation for Existential Therapy, 2016). This is especially appropriate, as practitioners report to work with a wide variety of diverse clients and clinical presentations presenting in primary care (Alexander et al., 2010) such as e.g. Depression, Anxiety, Claustrophobia, Agoraphobia, Obsessive Compulsive Disorder, Post-traumatic Stress and even Psychosis. In a way, this also exemplifies the existential notion of ‘existence precedes essence’ (Sartre, 1969) in its avoidance of essentialist definitions.

Yet, flexibility and responsiveness as defining features of EPP are also what creates a fundamental tension with the medical model predominant in primary care: in order to align primary care to the organisational values and practices of the managed care model of the NHS, emphasis is placed on generally applicable procedures such as diagnosis, psychometric measures, fixed session numbers and clear therapy structures. This makes it difficult for practitioners to justify their work in this context.

The resulting positions of the ‘therapist-as-other’ however, has a long-established tradition within the existential paradigm (Cohn, 1997; Cooper, 2003; Spinelli, 2003; van Deurzen, 2012); central to the existential paradigm is the assertion that therapists become other to the sedimented worldviews, strategies and behaviours of clients and are required

to remain open, flexible and creative, in order to be able to make the consequences following from these sedimentations explicit. Therefore, *otherness* and rebellion is cultivated almost as an existential trademark. Spinelli says:

The existential psychotherapist is 'the other' in the therapy world whose inclusive otherness discloses and challenges the client's self and world-constructs, and, hence, the client's worldview as a whole (Spinelli, 2007, p. 113).

Further, as a relatively recent therapeutic practice, certainly in the UK, and as a reactive perspective that poses a challenge to established forms of psychotherapy, maintaining the role as 'Other' might also function to delineate practitioners' identity from other professionals (Tajfel, 1982), however there is little evidence in the data to put forward a grounded hypothesis.

However, it might be this paradoxical tension, the adoption of an outsider perspective, that allows practitioners to scrutinise primary care procedures for their usefulness and 'therapeutic-ness' in the face of client needs and engage in a critical practice. As outlined in the following sections, rather than avoiding paradoxes and tensions, practitioners in this study actively take their position as 'Other' as a starting point, they 'join in' as Rayner says (Rayner & Vitali, 2013). Spinelli (2007) talks about "embracing the alien worldview of the client" and seeking to "permit that worldview to co-habit the therapy world" (p.109), an attitude that practitioners in this study have translated to the context of their work: they have invited the alien 'medical model' to co-habit their therapy world. This finding then, that *otherness* might function as impetus and driving force to work within the contrasting practice environment of primary care is of potential value to the community of existential practitioners: it might help to diminish anxieties of 'compromises in identity' as a result of working in settings such as primary care (Schneider & du Plock, 2012). It also might present a call to practitioners to be forthright in grasping their existential heritage and engage with it, rather than be held back by it (van Deurzen, 2012).

6.2.3. Negotiating Practice in Primary Care

A significant finding of the current research is that practitioners' active engagement with their *otherness* and the tensions that the particular version of the medical model in primary care poses to EPP, lead to a shift in their experiences and allows them to develop a new perspective. In turn, this helps them to successfully practice in primary care. This is outlined in the major category 3, 'Negotiating Practice in Primary Care'.

This shift in perspective, from initial scepticism towards an active engagement in finding common ground between the existential position and that of the primary care setting, presents an important outcome of this research. Primarily, it confirms the hypothesis that practicing EPP successfully in primary care is indeed possible and further, that practitioners experience it to be a valuable practice. This adds to the voices suggesting a fit specifically between the British School of EPP and the primary care context (Rayner & Vitali, 2013; 2015) and possibly also the wider NHS (Barnett, 2009; Claessens, 2010; Rayner & Vitali, 2013; Steel, 2010; Tantam & Kumar, 2009). Therefore, this study also

provides a tentative response to those voices in the wider literature on the existential therapies that call for a dialogue with the medical model (Keshen, 2006; Lantz & Walsh, 2007; Melton & Schulenberg, 2008; Schneider & du Plock, 2012; Vos, Cooper, Correia, & Craig, 2015).

Further, in the light of the lack of practice-based research, this study highlights the importance of enquiring directly with practitioners in a systematic way (Addis et al., 1999; Chorpita, 2002): practitioners' perspectives add a valuable voice to the predominantly critical stance of the British existential community towards the medical model (Cohn, 1997; Spinelli, 2007). Practice-based research and 'insider-narratives' might have the potential to challenge existing narratives. Moreover, such research might be able to add details and nuances to existing narratives: certainly, the present study describes a process of change in practitioners' attitude as a result of the exposure to a particular practice context. This brings home what a number of authors in the field of existentialism (de Sousa, 2004; Wilkes & Milton, 2006) but also in the wider field of professional practice (Ronnestad & Skovholt, 2013; Schön, 1995) have recognised as the transformative result of emersion in practice. Research on novice professionals within the first five years post-qualification, for example (Ronnestad & Skovholt, 2013) has shown that these professionals often realise the important impact that the context in which they work has on the way they provide therapy, above the more theoretical and 'context-free' notions that they might have learned throughout training. This might be especially relevant, not only for novice practitioners, but for EPP as a relatively young form of practice, certainly within the NHS.

The way in which practitioners describe the process and shift in their perspectives is also noteworthy: practitioners talk about recognising dilemmas such as having to work within a medicalised framework of distress, bracketing and suspending their preconceived notions of the significance of these, and enquiring into the personal relevance and applicability to clients. There are marked similarities to how the literature on EPP describes the process of acceptance of life's 'Givens' (Cohn, 1997; Cooper, 2003; Spinelli, 2007; van Deurzen, 2012) which leads to the potential to gain freedom within these limitations, rather than freedom from them (Kierkegaard, 1955; Sartre, 1969). Cooper for example talks about the importance of being "more accepting of the inevitable limitations and 'unknowns' in developing a close, therapeutically-healing relationship" (Cooper, 2003, p. 104). Spinelli (2007) in turn, draws on the Heideggerian concept of 'thrownness' to argue that there is not always a choice to be chosen, but sometimes therapy is about changing the interpretation and meaning of 'Givens'.

These similarities between practitioners' accounts and the wider existential literature do not seem coincidental, nor is it surprising that practitioners standing in the tradition of existential philosophy would describe their own process of change in this way. However, it draws attention to a narrative and conceptual tool that is already established within EPP's tradition: understanding the negotiation of the tensions of different contexts and philosophies (e.g. EPP in primary care) in terms of a process of engaging with limitations and 'Givens' might be useful for the training of practitioners and might provide those practitioners who want to work in a context such as primary care a conceptual framework

to manage the tensions that emerge. In fact, some practitioners in this research certainly frame negotiating tensions arising out of the practice context of primary care as an essential part of their learning process in becoming more skilful therapists.

However, at the same time, the link between practitioners' shifting perspectives and the exposure to the practice context of primary care which this research finds might benefit from further research. For example, the current research does not explore the reasons why practitioners chose to work in primary care in the first place which, in turn might mediate their experiential shift. Further, it might be important to verify the current findings in different practice contexts and with a larger sample to establish their validity beyond this particular study.

The following sections discuss the different aspects of practitioners' shifting experience and the negotiation of EPP in primary care in more detail.

6.2.3.1. Time and Limitations of Time

According to the interviewed practitioners, the impact of time-limits form an important aspect of the negotiation of EPP in primary care and therefore a separate sub-category emerged in the presented grounded theory. The brief time-frame is a fundamental distinguishing aspect between EPP in primary care and 'generic' or 'pure' EPP. This section first of all, relates the issue of time and time-limits to the wider literature on EPP. Subsequently, it discusses the practice dilemmas of working within a brief framework, comparing the way in which practitioners negotiate this to other brief existential models. Finally, the issue of 'directiveness' is discussed and questions for future research are outlined.

Like the majority of authors of the British existential tradition, interviewees in this study place importance on acknowledging the temporal frame in which therapy inevitably takes place (Lamont, 2012; Weixel-Dixon & Strasser, 2005). However, in contrast to the prevailing emphasis of open-ended working within the body of the literature (Cooper, 2003; Spinelli, 2007; van Deurzen, 2008), practitioners in this study articulate the value and usefulness of time-limited, brief ways of working. This adds to the surge in such voices over the last decade in the wider field of the existential therapies (Breitbart et al., 2010; Cooper, 2003; Fegg et al., 2013; Fillion et al., 2009; Henry et al., 2010; Langdridge, 2006; Lantz & Walsh, 2007; Lee, Cohen, Edgar, & Laizner, 2006a; Rayner & Vitali, 2015; Schneider, 2008; Vos et al., 2007). Thereby, it also contributes to placing EPP in a better position to take up the demands that settings such as primary care and managed care in general place on the psychotherapies.

However, time-limits also present a particular practice dilemma because it necessitates an adaptation of practice. As outlined in the previous section, brief time-frames require a shift in practitioners' attitude, towards accepting them as 'Givens'. Further, practitioners identify three elements of brief work, namely the faster pace, their own proactive-interpretative engagement with the client material and the selective focus of the therapy, which need to be balanced with the openness of the phenomenological method. While

there is some variation in terms of which end of this spectrum practitioners emphasise, the majority tend to work in a more directive way.

Similar to the most prominent EPP model on time-limited practice, Strassers' (1997) 'Wheel of Existence', practitioners note the limitation of time to result in 'urgency' within the therapy. However, notably, the way in which practitioners in this study describe their proactive way of working is somewhat different in tone and emphasis to Strassers' model, which is more critical towards proactively shaping the direction of therapy. Notably, Strasser and Strasser offer a modular way of working which includes the possibility of additional sessions, whereas this possibility is not open to practitioners in this study on account of the organisational structure of primary care. Therefore, time-limited practice in this study is more aligned with the brief existential model that Rayner and Vitali (2013) put forward, emphasising the active way in which practitioners shape the therapy.

The turn towards a more proactive way of working, raises the question whether practice in primary care, results in a shift towards a more directive way of working than EPP is traditionally comfortable with (c.f. Cooper's 'Directive' vs. 'Non-directive' dimension in Cooper, 2003). Certainly, in managed care settings beyond the UK, where there are a number of more broadly existential (as opposed to existential-phenomenological) interventions, a focus lies on a proactive and more directive way of working (Breitbart et al., 2010; Fegg et al., 2013; Fillion et al., 2009; Henry et al., 2010; Lee, Cohen, Edgar, & Laizner, 2006a). This is even true for those interventions that stand in a more experiential/phenomenological tradition (e.g. van der Pompe et al., 2001; Vos et al., 2007).

On the other hand, the finding of this research, namely that existential-phenomenological practitioners in time-limited contexts actively direct the therapy while at the same time attempting to stay within a phenomenological framework, can also be interpreted differently: it might also expose the dichotomy of being directive versus being phenomenological that traditional British existential lore poses as somewhat of a red herring. As McAteer (2010) in his research comparing existential therapy and CBT, and Mantica (2011) in her research on counselling psychology practice point out, direction, interpretation and influence form an important aspect of therapy independent of the approach. As van Deurzen further argues, it might less a question of directive vs. non-directive, but rather "directional, purposeful and searching instead" (van Deurzen, 2008, p. 35). Therefore, it might be more important to inquire into how this takes place in practice, a call to which the present research provides a tentative reply, by posing therapy pace, proactive-ness of the therapist, the extent to which clients' meanings are interpreted and openness of exploration as aspects that therapists need to be mindful of. As the present research shows, therapists' preferences might also play into this, as not all practitioners practice in the same way.

Overall, the findings around practicing in the context of primary care open up the opportunity for a more nuanced dialogue about how to work existential-phenomenologically within brief time-frames that is absent in the reviewed literature. They also might provide practitioners in time-limited settings with a basis for reflecting on their practice. Further research on actual practice might help to ground the current

findings and help to answer the questions posed around the different constituent parts of the notion of ‘directiveness’ in brief EPP.

6.2.3.2. Structure & Goals

Therapy structure and goal setting emerges as another subcategory within the third category of this grounded theory. In the following, this subcategory is discussed in the light of British existential literature and the broader existential literature. The wider issue of goal-setting and case-formulations is also touched on.

Structurally, EPP in this study is presented as flexible and open, in that there is no discernible common structure across the course of therapy, but rather the topics discussed in each session are responsive to the particular client. This is in line with the general attitude of the British School of existential therapy which favours a non-directive and spontaneous way of working (Cooper, 2003; Strasser & Strasser, 1997). It is therefore very different to most of the manualised brief existential interventions developed outside the UK (Breitbart et al., 2004; Fegg et al., 2013; Lee, Cohen, Edgar, & Laizner, 2006a; Spiegel & Spira, 1991; van der Pompe et al., 2001). At the same time, the open-ended structure frequently stands in tension to the expectations on behalf of the medicalised setup of primary care and therefore also to the expectations of clients for therapy to follow a linear course: from problem identification, goal setting to problem solution and outcomes.

The practice of setting aims or goals for therapy or setting out an initial hypothesis of clients’ concerns which practitioners variously report, presents a somewhat contentious notion in the literature on time-limited existential and EPPs. Certainly, Strasser and Strasser (1997) are very clear that goal-setting, while tempting in the light of time pressure, is “inapplicable” (p.60) to brief existential therapy as it compartmentalises concerns that are complex and interlinked. Rayner and Vitali (2013; 2014) on the other hand stress the importance of goal-orientation in brief existential therapy in primary care as a way for clients to assess “themselves and the therapeutic experience” (p.3) and as a way to measure therapy progress. This view is shared by Langdridge in his integration of existential therapy and solution-focussed work (Langdridge, 2006). In the wider field of the existential therapies, both Bugental (2008) and Lantz (2007) argue to meet the limitations of time through a focus on particular concerns. Equally, frameworks such as Cooper and McLeod’s pluralistic framework (Cooper, 2010; Cooper & McLeod, 2010) emphasise goal-setting as a fundamentally client-centred way of providing an individualised form of therapy.

The present study provides a contribution to the existing literature as it outlines how practitioners in real-world practice negotiate these tensions in a way that attends to both positions: rather than altogether forego the use of goals or alternatively resign themselves to making use of goals in a rigid way, practitioners in this study use goals as a reference point. Importantly, practitioners attempt to align client expectations by spending some time in the initial phases of therapy exploring their goals and ideas about the outcome of therapy. Practitioners also acknowledge that concerns might change throughout therapy

and that setting goals might function, both in order to remind the client-therapist dyad what they originally set out to accomplish and also as a map of the process of therapy which can be updated along the way. This becomes also evident when practitioners talk about using at times a more formal goal setting tool, namely the CORE Goal Attainment form (Barkham et al., 2001) from a process-oriented, phenomenological perspective, rather than a more rigid, prescriptive perspective. Moreover, this ties in with what has been termed, appropriate responsiveness (Cooper, 2009; Norcross, 2011): the question of whether to work in a goal-oriented way or not might present a red herring. Rather, the importance might lie in paying attention to the process of relating the therapeutic work to expectations, desires and needs of clients in a flexible, yet purposeful and directed way. This appears pertinent, particularly in the light of the existing range of literature that links client expectations to therapeutic outcomes (Castonguay, 2005; Cooper, 2008).

The outline given by the present research might add to inform an existential perspective on primary care work and possibly other managed care settings where goal-setting forms part of the established procedures. While the current study provides an outline of this, a more detailed exploration at a micro-level and on the basis of actual therapy sessions might verify whether this provides a valuable addition to routine practice.

Notably, at least some of the interviewed practitioners appear to engage in a process of building hypothesis or theories around their client presentations, especially in order to make best use of the limited time available, which has been suggested by Hersch (Hersch, 2011) in his preliminary outline of an existential case formulation and is an accepted, if not required, part of other psychological approaches (Division of Clinical Psychology, 2011). There is a question whether more in-depth inquiries into the process of this at practice level might uncover more commonalities between EPP and other therapeutic approaches than presently acknowledged.

6.2.3.3. Measures as Phenomenological Tools

The use of psychometric measures is, at least initially, experienced by participants as presenting a tension. As participants learn to work in primary care, they start to use psychometric measures as a phenomenological tool. In this section, this process is located within the wider literature and the wider question of how to approach the measurement of EPP is discussed.

Psychometric measures are often initially problematised by interviewed practitioners, as it is assumed to interrupt the client-lead structure of the therapy session and has the potential to reduce the holistic perspective that practitioners aim to take towards the clients and their concerns. However, over time, practitioners successfully incorporate such measures into their work as ‘Givens’, even though this might not always be their preferred way of working and even though the use of measures continues to be a tension in their work. Employing measures at the beginning of therapy is described as providing a departure or orientation point in reference to which clients’ concerns are discussed. This is particularly pertinent when working within brief timeframes, where an emphasis lies on establishing a direction for the client work early on. Further, practitioners also engage in a

phenomenological exploration of the meaning that clients ascribe to psychometric measures and their response to framing their experience through them. This may also include, as one of the participants points out, to re-interpret measures from an existential perspective, that is to explore e.g. rising anxiety scores as a sign of becoming aware of life's possibilities.

The way in which practitioners balance both the demands placed on them and the existential values they subscribe to by adopting a phenomenological attitude and by using psychometric measures as phenomenological tools forms an important finding: especially in the light of the general scepticism towards any form of psychotherapy measurement within the existential community (Cohn, 1997; Cooper, 2003; Spinelli, 2007) it puts forward a conciliatory way of working. It suggests that measuring therapy does not necessarily have an adverse impact on the therapeutic relationship, or necessarily 'technologises' the relationship between client and therapist as some existentialists fear (Cohn, 1997; Spinelli, 2007). As Rayner and Vitali (2015) argue, it allows practitioners to work in the 'medical' primary care setting while at the same time preserving their identity and indeed drawing on useful aspect of psychometric measures as a tool of engaging clients.

This appears particularly pertinent as the need to use measures to evidence practice forms an integral part of primary care (Alexander et al., 2010; Rayner & Vitali, 2014) and the wider movement of evidence-based practice (Chwalisz, 2003; Norcross et al., 2006) in the NHS. As Rayner and Vitali (2014) point out: "we cannot avoid the issue of measurement simply because it is problematic" (p.305).

At the same time, however the findings of this research also indicate that practitioners remain sceptical towards the validity of therapeutic outcomes established through psychometric measures, for their work with individual clients. Practitioners appear somewhat torn between recognising the value of generalising outcomes beyond individual clients as a way of communicating the success (or not) of their work and the risk they perceive to de-individualise and de-humanise their clients. Several practitioners described the contribution of their work to primary care in terms of its empirical evidence, which they had collected as part of their practice; others in turn felt that measures did not adequately represent their work.

While the findings of the present research cannot provide commentary on the value of evidence that psychological measurement systems provide, it outlines a perspective on the process of engaging with them, which is absent in the current literature, certainly in the UK. Using psychometric measures as a 'phenomenological tool' also carries the potential to give rise to a broader discussion about what it means to work from an existential stance (Spinelli, 2007): it raises the question whether a phenomenological focus on the process of using measures rather than their purpose or utility might help both practitioners and clients stay engaged with the therapeutic space, rather than having to abandon it on account of its irreconcilableness with their values. It might also open up dialogue with the wider existential tradition outside of the UK, which while not subscribing to the phenomenological method in the same way, seem to be more open to consider psychometric measures (LeMay & Wilson, 2008; Vos, Craig, & Cooper, 2015b; Walsh &

McElwain, 2002) as a way to evidence their work. Further, it might provide some reassurance to those therapists who want to take up the challenge to evidence existential with traditional outcome measures (Rayner & Vitali, 2013) or indeed more existentially oriented measures such as the Purpose in Life Test, Seeking of Noetic Goals Test (Melton & Schulenberg, 2008), the Meaning in Life Questionnaire (Steger et al., 2006) or Ryff's wellbeing scales (Ryff & Keyes, 1995) by providing a tentative outline of a 'how-to'.

Alternatively, goal-setting and following up the achievement of set goals towards the end of the therapy has been promoted in the literature of psychotherapy (Newton, 2002; Winograd & Shick Tryon, 2011) and also more recently in the existential literature (Rayner & Vitali, 2014) as an individualised way of enquiring into the outcomes of therapeutic working. This might form an alternative to the typically administered generic psychometric tests and might be more palatable to practitioners. Further, given the wide range of concerns clients present with, especially in settings such as primary care, this might provide a more sensitive form of measurement.

However, as Marginson et al (2000) point out, different stakeholders for example, individual practitioners, the client-therapist dyad, the wider service and governmental bodies (e.g. NICE, IAPT) might have different priorities concerning the measurement of psychotherapy. Therefore, it might be important to recognise that a focus on outcome and effectiveness measures, such as those used this study, might not be a priority for the individual practitioners or the practitioner-client dyad and that part of their scepticism might be rooted in this. Rather, they might be more interested in measuring personally relevant change, formulate client-concerns and enquire into the skilfulness of practitioners' interventions. It might be important to differentiate between the various purposes of measuring psychotherapy in order to facilitate a more nuanced dialogue.

In order to further such a dialogue, it might also be valuable to consider clients' perspectives and their experience of using psychometric measures, especially as clients' expectations of therapy impact on the therapy in a variety of ways (Ashworth et al., 2005; Cooper, 2008; Corrie & Callanan, 2001; Martin et al., 2012). Even though practitioners in this research report both positive and negative responses from clients, a comprehensive position lies outside the scope of this research and might therefore be usefully supplemented by research interviewing clients directly.

6.2.3.4. Psychopathology & Diagnosis

Working with and within the medical model of psychopathology presents another tension for the interviewed practitioners and this emerged as another subcategory.

The way in which practitioners problematise the use of diagnostic labels with clients as reductive, rigid and vulnerabilising has a long tradition within existential writings, especially with the British School (Cohn, 1997; Cooper, 2003; Spinelli, 2007; van Deurzen, 2012). At the same time however, practitioners in this study engage with this tension in a quintessentially existential way: in exploring the notion of diagnosis with clients rather than rejecting it in its totality they follow authors such as Spinelli (Spinelli, 2007), who

suggests to transform the question of whether a client suffers from a mental illness into an enquiry to shed light on the client's actions in their context. To the author's knowledge, the present study is the first study to outline how existential practitioners translate this in a practice context where diagnostic labels form an intrinsic part of therapy. Therefore it presents a valuable contribution to existential models of practice specific to primary care (Rayner & Vitali, 2015) but also other approaches to working in the NHS (Barnett, 2009; Steel, 2010; Tantam & Kumar, 2009; Weixel-Dixon, 2009). Being fluent in the use of diagnostic labels rather than rejecting them in their totality, while at the same time being mindful of individual meanings presents an important aspect of existential therapy in managed care contexts: given the fact that the majority of mental health services and referral pathways in the UK, including the newer programmes such as IAPT are organised in terms of 'diagnosis', practitioners from any theoretical perspective are likely to be required to accommodate to this reality to some extent if they want to remain within the public sector.

Notable among the findings of this research is the consensus among interviewed practitioners that there is no particular psychopathology for which EPP is better suited or more applicable. This is generally in line with the existing literature which reports existential therapy to be applicable to a diverse range of presentations (Adams, 2014; Arnold-Baker, 2005; Cooper & Adams, 2005; Corbett & Milton, 2011; Kirby, 2005; Kirkland-Handley & Mitchell, 2005; Madison, 2005; Milton, 1994; Pearce, 2011; du Plock & Fisher, 2005; Rayner & Vitali, 2015; Schneider & Fitzgerald-Pool, 2005; Smith-Pickard, 2006; Smith-Pickard & Swynnerton, 2005; Spinelli, 1997; Stadlen & Stadlen, 2005; Strasser & Strasser, 1997; Tantam, 2005; Thomas, 2001; van Deurzen & Tantam, 2005; Weixel-Dixon, 2009; Weixel-Dixon & Strasser, 2005; Young, 2005) however without establishing particular suitability (Cooper, 2003). Even authors such as Strasser (1997) and Langdridge (2006) who propose more specific models of working, largely eschew any discussion of psychopathology (and psychiatric categories) in favour of an emphasis on idiosyncratic concerns. Conversely, interventions developed outside of the UK (Breitbart et al., 2010; Henry et al., 2010; Kissane et al., 2004; Lee, Robin Cohen, Edgar, Laizner, & Gagnon, 2006b; Spiegel et al., 1999; van der Pompe et al., 2001; Vos et al., 2007) often make reference to pathological labels, if only in terms of physical health condition rather than in terms of mental health conditions.

Potentially, the particularities of the setting of primary care contribute to the lack of specificity with which participants describe of EPP: as practitioners point out, primary care attracts a significant variety of clients, sometimes with a specific diagnosis or specific concerns, sometimes without diagnosis and with little specificity to their concerns and therefore it might be quite difficult to entertain particular models of client 'pathology' or types of concerns in the light. Clients might not be usefully distinguished in terms of their commonalities, but rather their differences. In addition, given practitioners' expressed ambivalence towards the notion of classifying clients into categories in the first place, there is a potential that enquiring into specificity taps into interviewees resistance and shapes their accounts.

Overall, the present research provides some practice-based insight into working with psychopathology from an existential-phenomenological perspective. However, it is unable to answer calls for gaining a better understanding of the types of clients EPP practice might be helpful (Cooper, 2003; Vos, Cooper, Correia, & Craig, 2015). However, given the need at primary care level for a broad intervention that is able to accommodate a wide variety of client concerns, population specificity appear less prominent in this area. Yet, further, research, possibly at the level of actual interventions, in order to rule out practitioner bias, might usefully enquire into the relationship between types of client concerns and types of therapy outcomes.

6.2.4. *The Impact of Professional Experience*

A significant majority of interviewed participants in this study draw on their experience of working in primary care from in-training placements. Therefore, different degrees of professional experience form an important part of the theory of practice negotiation put forward in this research. In the following, this fourth major category is discussed with reference to the literature on professional learning.

First of all, the active negotiation of the *otherness* of the identity of in-training existential practitioners against the dominant culture of primary care, evolves partly around developing a degree of confidence in their practice as therapists. Practicing in primary care requires a 'solid sense' of practitioner identity as practitioners have to work in a proactive way often without being valued by other professionals or the medical model in their existential orientation. This is especially the case as EPP presents practitioners with a large degree of freedom and little practical guidance and therefore practitioners feel the responsibility placed on them quite strongly. In a sense, this appears very fitting for a kind of therapy that stands in the tradition of thinkers such as Kierkegaard who posed the idea of the 'dizziness of freedom' (1955). As a result however, novice practitioners experience a heightened sense of the tensions between their orientation and the values and procedures of primary care.

Given the lack of literature on the development of professional practice and identity in the field of the existential therapies (Adams, 2013), the findings of this research tread on novel ground and there is little to contextualise them with. Certainly, Ronnestad and Skovholt (2013) suggests that particularly in environments where a heterogeneous client group with a wide array of presenting concerns is prevalent, novice therapists experience feeling lost in their work environment and experience cycles of self-doubt and anxiety. The results of the current research certainly point to the potentially difficult practice environment that primary care presents, especially for novice practitioners. In fact, several of the interviewed practitioners are sceptical about choosing primary care as a first placement for trainees. However, at the same time, the question is raised whether some of the intensity with which *otherness* and tensions and practice dilemmas are described in this enquiry can be attributed to the large amount of novel practitioners participating. More experienced practitioners might experience the primary care environment as less challenging.

At the same time, the analysis suggests that on a practice level and in the way in which practitioners negotiate their practice there might not be a pronounced difference between experienced and less experienced practitioners. Certainly, both experienced and less experienced practitioners overall seem to be confident of the value of their work to clients, which according to Ronnestad and Skovholt (2013) is more commonly a feature of experienced practitioners. Moreover, although trainee-practitioners describe negotiating the primary care context often as “struggle”, this does not appear to weaken their commitment to EPP in general. On the surface, this appears at odds with the way Ronnestad and Skovholt (Ibid) describe novice practitioners as often being disillusioned with their training modality, which then leads to therapists re-assessing and critiquing the working models they use. However, the openness and flexibility of the existential tradition to back-up practitioners in their chosen way of working rather than prescribing certain practices might present a factor that positively impacts on novice practitioners’ sense of commitment to their existential roots. This might also contribute to the way in which practitioners, both novice and more experienced ones, are able to embrace the shift away from a ‘traditional’ existential way of working towards an adaptation to the primary care environment.

On the other hand, particularly less experienced practitioners in this study express that they would have valued more guidance when they started working in primary care, providing them with a more concrete outline of the different aspects of working in an existential-phenomenologically informed way. This is in line with Ronnestad and Skovholt (Ibid), who argue that early career practitioners actively look for structured sources of professional guidance such as proactive and didactic supervision, instructions and therapeutic guidelines as well as role models from senior practitioners. Equally, Cross says:

Guidelines for the training and practice of Counselling Psychology require the articulation of knowledge at a low level of abstraction. One means by which this may be achieved is through the identification of the essential or definitive features of the phenomena. That is, a naming of the building blocks of professional practice and an elucidation of the links between these activities and theory (Cross & Watts, 2002, p. 299).

Therefore, while operationalised models put forward by for example Rayner and Vitali (2015) and existential therapies from outside of the UK (Breitbart et al., 2010; Fegg et al., 2013; Spiegel & Spira, 1991), might not be welcomed by all practitioners as outlined in this chapter earlier, they might provide a valuable departure point for novice practitioners. However, rather than focussing on more prescriptive session-by-session outlines (such as those of Rayner and Vitali), they might be developed around the kinds of tensions and practice dilemmas that form part of working in a particular environment as explored in the present research. They might also suggest strategies to manage ruptures in the therapeutic work. Escudero (2012) for example, suggests to conceptualise guidelines more in terms of “a map that gives options than a SatNav that directs the journey” (p.109). Such a map might give guidance of alternative options at choice points marking “the path and possible alternatives, according to the rhythm and circumstances that each client brings into the therapy” (Ibid). Carroll and Nuro (2002) further suggest that such guidance needs to effectively integrate real world practitioners by inquiring into their

needs and mapping their contributions. The current research might provide a tentative outline for such an endeavour. This might be particularly relevant to the training of therapists. It certainly would have been helpful to my own practice as a trainee practitioner, had I had the opportunity for a systematic engagement with the kinds of contextual and other aspects that practicing within primary care brings.

Overall, while the transferability of the current study towards EPP at primary care level undertaken by experienced practitioners might be limited, it might be particularly applicable to novice practitioners and trainees. In fact, it presents the first enquiry into the perspective of novice practitioners practicing at primary care level and within an NHS context and therefore might provide a valuable foundation for future research into this area. It might also provide a starting point for the development of more concrete and structured guidance for novice practitioners, modelled on the tensions that practitioners experience and strategies that they employ to manage these as found in this study.

7. CONCLUSION

The final chapter presents my own reflective response to this study, before linking the findings of this study to the field of counselling psychology. In conclusion, the clinical implications that arise from this study are discussed, recommendations for the direction of future research are made and a summary is presented.

7.1. Author's Reflexive Response to the Research

Conducting this research has been both challenging and interesting on a professional but also personal level. Throughout the process of developing this research, there were a number of occasions where I found myself having personal reactions to both the subject and the subjects of my research. As I have already outlined in the epistemology and methodology of this research, the involvement of my 'personal' self is not only expected but to some extent necessary for the interpretative aspects of this kind of research. However, I feel that it is important that I make transparent some of the instances of being 'personally involved' that I considered to be more significant.

Interviews

Conducting the individual interviews and the also the focus group has been challenging at times as it required me to shift my position from my more natural position as trainee counselling psychologist and existential therapist to that of researcher.

First of all, this included to be mindful not to influence the course of the interview through any pre-conceived ideas. This was particularly the case as I was acutely aware of enquiring into an area that exists somewhat outside the main-stream of both EPP and clinical practice in primary care. Therefore, this research inevitably takes on a political dimension of potentially being able to legitimise and articulate an underexposed area. Throughout the research supervision process and especially the process of writing down my own reflections I became aware of the ways in which I wanted this research to contribute to the field and how at times I preferred certain answers to my interview questions over others for this reason. Reflexively questioning my own biases throughout the data transcription and analysis process helped me to counter steer such instances or at least make them explicit.

Secondly, given my own experience of primary care I was inevitably placed in a position of 'colleague' to the practitioners interviewed for this research, as already outlined within the methodology chapter. On one hand, this was conducive to the research process in that I could draw on my 'inside-perspective' and my status as a fellow therapist to facilitate an in-depth and highly sensitive dialogue. However, on the other hand it was difficult at times

not to unreflectedly 'fall' into a conversation between peers; especially as some of the dialogue between myself and the participants seemed to genuinely facilitate their reflection on their own practice. My training as therapist was very helpful in navigating this dilemma of multiple selves and allowed me to be aware of occasions where this was likely to happen or had happened.

At the same time, I had initially experienced an acute sense of responsibility towards the practitioners participating in my research as it felt that it was limited what I could offer them in return for their participation. However, most participants explicitly commented on the usefulness of the interview to their own practice and the opportunity to articulate their perspective as a minority group within the NHS.

Analysis

Throughout the process of conducting the present research I felt very grateful for the participation of practitioners who gave me rich and insightful accounts of their experience. This resulted however in a dilemma, as I found it challenging to prioritise the analysis of their accounts in such a way that addressed specifically the research question.

First of all, the participating practitioners made reference to a wide range of important aspects of practice but they were not always within the scope of this particular study and therefore I needed to be selective in terms of the content I included.

Secondly, I was also acutely aware of the richness and nuances of practitioners' accounts and at times it felt frustrating and anxiety-provoking to subject these to analytic procedures which move them away from pure descriptions. My aim to stay true to the richness of interviewees' experience, while at the same time satisfy the aim of this research and its epistemological/methodological stance to arrive at an interpretation valuable beyond this specific context frequently stood in tension to each other. When I started this research, it was very important to me to provide research findings that have the potential to be valuable for the wider community of existential therapists and counselling psychologists, especially because many research projects I had seen in this field did not go beyond description and felt somewhat limited in their clinical application. In fact, this formed part of the reason why I chose grounded theory as a research methodology. While analysing the data however, particularly as a novice researcher and possibly also due to my training in EPP, I was anxious to stay close to participants' idiosyncratic descriptions. Frequently, I was worried about straying too far from what participants said, least not to lose the grounding of my analysis in actual data. At times, I wondered whether a more descriptive methodology, based on a phenomenological perspective such as descriptive phenomenology (Finlay, 2008; Giorgi, 1997) or even IPA (Shinebourne, 2011b) would have suited my 'natural style' better.

Discussions with my supervisors, the input of fellow researchers and doctoral students and the revisiting of philosophical texts, especially material by Heidegger (e.g. Heidegger, 1994), proved very helpful and reminded me that any analysis ultimately is an interpretive exercise which includes the loss of some aspects but also the creation of new insights not

captured by the original data. Therefore, after concluding the member check and as already outlined in the previous chapter, I revisited the data from a more interpretative perspective and with a renewed engagement with the theoretical underpinnings of grounded theory in a post-modern version (Charmaz, 2005). As a result, the final version of the grounded theory put forward in this research is more interpretative than that presented to participants. Retrospectively, I became aware that these reflections might have been useful at an earlier stage of the analysis, so that their outcomes might be verified or reflected on during the member check phase of this project however, as a novice researcher my own process was not sufficiently developed at that stage. On one hand, this might be considered a limitation of this research, on the other hand member checks have no pre-defined place within the development of a constructionist grounded theory (Charmaz, 2006), and it is my experience that the member check encouraged me to be more creative and reflective in my conceptualisation of this research and therefore the overall process contributed to the quality of this research. Certainly, this is one of the learning points I am taking away from this research project.

Thirdly, the established academic standards of structured narrative accounts forms another example of difficulty I encountered in the analysis of the research data. It felt at times that the linear nature of narrative forms of representation is limited in the extent in which it can capture the often multi-layered and interwoven relationships between aspects of data: practitioners are very competent speakers and therefore their accounts often do not follow a linear way and incorporate multiple layers of meaning. Sometimes it would have felt more appropriate to represent the data in diagrammatic form, however this comes with its own limitations such as a reduction in accessibility for the reader and a reduction in descriptive information that can be reasonably associated with a diagrammatic representation of relationships; i.e. in spider diagrams or flow charts the amount of text is limited. As a result, I have taken the decision to provide some form of diagrammatic representation but also a traditional narrative structure, which I hope work in conjunction with each other to provide a comprehensive overview of the analysis.

Revisiting the Data

Towards the completion of the present research, especially throughout the process of writing up the final report but also thought the ongoing research process, I read over my analysis of the data several times. The process of this made me aware that I had on occasions different responses to the data than on previous readings and I found myself re-analysing and re-evaluating my previous interpretations on the basis of the knowledge, insights and experiences that I had collected in the meantime. Therefore, a salient response to the research is the subjective and contextual nature of Grounded Theory and my epistemological design in particular but also of qualitative research in general.

I became very aware that this research is placed in a particular context that includes the physical, emotional, intersubjective and temporal milieu: I conceived and wrote this research at a particular time in my life with particular questions in my mind and equally my intersubjective encounter with participants took place in a certain environment which all

impacted on the analysis, findings and structure of this research project. I have tried to capture some of these aspects by seeking the feedback from participants at a different point to the original interview and I have attempted to track my own changing circumstances through reflections exercises, such as my research diary, research supervision, contact with colleagues and friends, as well as personal therapy. However, none withstanding this research is a product of particular circumstances and might take on another form under different circumstances. This is both anxiety-provoking as it leaves me questioning whether I have made the ‘right’ analytic decisions but also reassuring in the sense that ultimately the ‘right’ decisions for some future point might not be the ‘right’ decisions at this point and the current research can only be read in its context and it is up to the reader to decide on its validity for his/her particular context.

7.2. Relevance to Counselling Psychology

Beyond the field of existential therapy, the findings of the present research are also of wider relevance: particularly they provide relevant knowledge to the practice of counselling psychology, specifically within primary care settings but also potentially other managed care settings in the NHS.

Counselling psychology practice within the public sector, with its subscription to the scientist-practitioner model (Blair, 2010), has faced the challenge of bringing together “respect for the personal, subjective experience of the client” (Corrie, 2000, p. 414) with the managed care model of the public sector. As the NHS, including primary care programmes such as IAPT, present a major employer for counselling psychologists, this endeavour has become a central professional task for counselling psychology. At the same time, as outlined in the introductory chapters, counselling psychology in the UK significantly draws on the existential tradition to provide it with a fundamental value-base and a core model of practice. Therefore, the findings of the present study present an important contribution to counselling psychology practice within the public sector. The fact that four of the interviewed participants were in training towards a qualification in counselling psychology at the time of the interview further increases this relevance.

Overall, the overlap between existential therapy and counselling psychology practice put forward in the review of the literature find some validation in the findings of this research. Specifically, the presented theory contributes to providing a more detailed understanding of negotiating the tensions and opportunities within primary care and potentially other ‘medicalised’ managed care settings: the way in which practitioners construe ‘medicalness’ to form a focus of practice requiring the adaptation and negotiation is outlined in a similar way in counselling psychology literature (Hemsley, 2013a; 2013b; Konstantinou, 2014; Lamproukou, 2014; Mantica, 2011; Papadomarkaki & Lewis, 2008). This includes the proactive and at times directive negotiation of time-limits of therapy (Lamproukou, 2014), the management of client expectations with regards to the therapy structure and outcomes (Lamproukou, 2014), the problematisation of psychometric measures (Karademas, 2009; Lamproukou, 2014) as well as the ambivalent

stance towards psychiatric diagnosis (Lamproukou, 2014; Larsson et al., 2012) that practitioners take.

Markedly, the way practitioners in this study describe the setting of therapeutic goals also appears in line with Cooper's (2009) suggestion to draw on goals as a way to individualise counselling psychology interventions. Indeed, two of the interviewed practitioners make reference to the usefulness of formalised goal-setting through use of the CORE Goal Attainment Form (Barkham et al., 2010b) which resonates with Cooper's 'Therapy Feedback Form' (Cooper, 2009; Cooper & Mcleod, 2010) to establish both feedback on the therapy but also to increase the fit between therapist and client perception of the therapy.

Further, by providing a tentative outline of working with the tensions that models of psychopathology and psychiatric diagnosis present within primary care settings, the current study answers calls as to how counselling psychologists can "draw on diagnoses and psychiatric knowledge without falling prey to it" (Cooper, 2009, p. 127): that is, by exploring the meaning that clients attribute to diagnostic labels as well as the function they serve within the primary care context, while at the same time challenging interpretations that 'pathologise' legitimate concerns.

The present research also affirms the importance of the practitioner as a person and his/her sense of self for the therapeutic process in actual practice, above more theoretically-driven therapeutic interventions which has been variously found to form an important part of counselling psychology practice in the NHS (Lewis, 2012; Papadomarkaki & Lewis, 2008) and indeed the wider field of psychological interventions (Norcross, 2011).

As further outlined in detail in the review of the literature, counselling psychologists within medical model settings - like practitioners in this study - undergo a process of practice and identity (Bernard, 1992; Mrdjenovich & Moore, 2004) negotiation which is perceived as challenging, is fraught with uncertainty, and requires balancing the organisational procedures with the needs of the clients. Particularly, trainee counselling psychologists (Rizq, 2006) need to tolerate the ensuing ambiguity and uncertainty that this negotiation causes. However, ultimately, practitioners are able to practice within the NHS while holding on to their values (Lamproukou, 2014). Therefore, novice counselling psychologists and counselling psychologists in training might find some inspiration, guidance and empowerment in the outline of practice dilemmas in this study and the strategies of negotiations those.

Different to practitioners in this study however, counselling psychologists tend to explicitly draw on a pluralistic stance, that is they integrate for example their humanistic-existential value-base with more traditional positivist-scientific perspectives inherent in the scientist-practitioner model and practices that draw on 'medical' attitudes towards the administration and evaluation of treatments inherent in some forms of CBT (Konstantinou, 2014; Mantica, 2011). Indeed, Hemsley (2013a; 2013b) and Mantica (2011) report that the adoption of a pluralistic identity allows practitioners to manage the negotiation that the medical model pose to them.

Practitioners in the current study on the other hand, even those four participants training to qualify as counselling psychologists, do not tend to make reference to working pluralistically. As outlined earlier with reference to the integration of different models of practice ('EPP in Primary Care'), this might be an artefact of the focus of the research design on existential therapy, rather than other practices, which might have resulted in practitioners emphasising one part of their practice over other parts. The fact that the interviewed practitioners are still in training towards a qualification in counselling psychology, might also have resulted in their focus on EPP, rather than practices connected to an identity they did not yet fully assume. The fact that all the interviewed participants trained at either Regents University or the New School of Psychotherapy and Counselling which both stand at the centre of the emergence of existential therapy in the UK (Correia et al., 2014; Spinelli, 2001; van Deurzen-Smith, 1997) might have further impacted on practitioners' identity.

At the same time, practitioners in this study flexibly draw on a range of conceptualisations from a wide range of existential and phenomenological sources under the umbrella of an existential-phenomenological 'attitude' and adapt these to take up the challenges that the primary care environment presents. This could be seen as the acknowledgement of the usefulness of taking multiple perspectives, albeit in a less explicit fashion than counselling psychologists traditionally do. Therefore, the detailed theory that the present research puts forward on the way practitioners manage these perspectives might contribute to gain a better understanding how the adoption of a pluralistic way of working takes place in actual practice. This might form the basis of further research on how the profession of counselling psychology can successfully find its place in the public sector without losing its identity. Especially in the light of the evidence that frames maintaining multiple viewpoints within a pluralistic model of practice as a challenging and complex professional task (Lowndes & Hanley, 2010; Thompson & Cooper, 2012) the current study might provide valuable insights. In turn, this might help to develop the evidence-base of counselling psychology practice (Chwalisz, 2003; Cooper, 2009).

Further research might need to establish a better understanding of the relationship between pluralism within counselling psychology and the way in which existential-phenomenologically trained practitioners draw on and integrate the wide range of practices and concepts available to them.

7.3. Implications for Clinical Practice & Training

Being situated within the realm of counselling psychology and an epistemology of practice, this study places importance on the implications of its findings to practice contexts. This includes the practice of existential practitioners, including novice practitioners and trainees, as well as the practice of counselling psychologists and the practice of delivering psychological services.

Clinical Practice

First of all, the finding that existential-phenomenologically oriented clinicians practice successfully within a primary care context, despite some initial scepticism and despite at times experiencing this setting as challenging, hopefully encourages those practitioners who might be uncertain about the fit of EPP with the primary care environment. Thereby, the findings might speak to a group that is underrepresented in the existing literature and those who might not recognise themselves in the prevailing discourse around existential therapy and help them towards emancipation. Therefore, this research is mostly valuable to the existential community.

The outline of the tensions and practice dilemmas that practitioners encounter in this setting, as well as the kinds of strategies that help practitioners to navigate these, set out a concrete and practice-based framework that goes beyond currently available literature and that might help practitioners in fitting existential therapy to the primary care environment. It might also provide them with inspiration for their practice, which might also be usefully extrapolated to NHS and managed care contexts beyond primary care as outlined in the above sections.

First of all, practitioners talk about recognising context and practice dilemmas such as having to work within a medicalised framework of distress, bracketing and suspending their preconceived notions of the significance of these, and enquiring into the situational and personal relevance to clients. Understanding this negotiation in terms of a process of engaging with limitations and ‘Givens’ provides practitioners with a narrative and conceptual tool that is already established within EPP’s tradition and that practitioners might use for example as part of the supervisory process in order to frame and approach practice dilemmas.

Secondly, participants identify three elements that fundamentally impact on adapting existential therapy to the brief time-frames given in public sector settings: namely the faster pace, the necessity of a more proactive-interpretative engagement with the client material and the selective focus of the therapy. Explicitly incorporating these aspects into working within brief time frames might help practitioners to work in a more focussed way. Especially as practitioners traditionally prioritise the non-structured openness of the phenomenological method (particularly in the British school) this might be a valuable addition of practicing in time-limited contexts.

Thirdly, some of the participants in this research outline an approach to working with therapeutic goal-setting which might be usefully incorporated into a wider existential practice that is explicitly and measurably responsive to client concerns: practitioners explored client expectations and goals at the initial stages of therapy, at times using formal tools such as the CORE Goal Attainment Form (Barkham, et al, 2010). While practitioners acknowledge that concerns might change throughout therapy, goal-setting might function, both in order to remind the client-therapist dyad what they originally set out to accomplish and also as a map of the process of therapy which can be updated along the way. Whether this is accomplished in a formal way through a standardised tool or in a more informal way, paying purposeful and directed attention to the process of

relating the therapeutic work to expectations and desires might be important to clinical practice. Particularly, within brief-time frames this might help to keep therapeutic work on track and manage expectations of clients.

Fourthly, while the present research cannot provide evidence of the effectiveness or efficacy of EPP in primary care and it also cannot provide a commentary on the value of evidence that psychological measurement systems provide, it can provide a perspective on the process of engaging with psychometric measures for clinicians. This is particularly important as evidence-based practice has become a permanent feature of the public sector and a discussion of this is mostly absent in the existential literature, certainly in the UK. Using psychometric measures as a ‘phenomenological tool’ as described in the findings of this research suggests that measuring therapy does not necessarily have an adverse impact on the therapeutic relationship. Therefore, this research puts forward a conciliatory way of working that might encourage practitioners to make use of psychometric measures which deliver the kinds of evidence that managed care providers ask for while at the same time staying engaged with the therapeutic space and client concerns.

Finally, while the current study is unable to make any recommendations as to which particular diagnosis or client group is more suitable for EPP in primary care, it does put forward a way of working with diagnostic categories which is currently underrepresented in the existential literature: practitioners in this study acknowledge the ubiquitousness of diagnostic labels and psychopathological categories, especially given the fact that the majority of mental health services and referral pathways in the UK are organised in terms of ‘diagnosis’. At the same time, and contrary to the established existential paradigm practitioners take these labels seriously in the sense that they explore together with clients the meaning and meaningfulness of them. Therefore the emphasis on ‘depathologising’ client concerns within the British school (Cooper, 2003) might require a rethinking in clinical practice in the public sector. Being fluent in the use of diagnostic labels rather than rejecting them in their totality, while at the same time being mindful of individual meanings presents an important aspect of clinicians practice in managed care contexts which might be a valuable addition to existential practice

Training

Especially for trainee therapists but also training institutions, the findings of this study present particular relevance: by providing in-training practitioners with the outline of a framework for EPP in primary care and with the previously outlined clinical implications, which shows the potential to be formalised into a practice guide, this study addresses the lack of guidance that participants raised in their accounts. Adding primary care practice as a formal element into the training programme of practitioners might both, empower trainees to work in primary care (or possibly in the NHS in general) and support them to develop the kind of confidence that practitioners posit as fundamental to their successful practice in primary care.

Further, the call for ‘contextualising’ EPP that emanates from this research, that is the call to pay attention to shared features of practice contexts, in addition to the idiosyncratic nature of the therapist-client dyad, might also usefully be integrated into the training of practitioners. The grounded theory that this research constructs on the basis of practitioners accounts, outlines clearly that the context in which EPP takes place impacts on actual practice. Therefore, this study encourages novice practitioners and trainees to engage with (real-world) practice-contexts of their work and enquire into the kinds of adaptations that practice might require to manage better the tensions raised. Thus, the findings of this research might enable trainees to distinguish between those elements that might be unique to their personal learning and those elements that might be shared by others. This in turn, might help them to have more effective dialogues with practice educators, supervisors and peers.

The results of this study also might help training institutions to make more informed decisions whether primary care presents an appropriate training-placement for particular students or cohorts of students with a particular level of experience. As a number of authors in the literature on learning point out, it is important to find a middle ground between stimulating and challenging students to encourage effective and positive learning (Leiman & Stiles, 2001; Ronnestad & Skovholt, 2013; Vygotsky, 1978).

While the points made above particularly apply to existential practitioners, they are also applicable to counselling psychologists who make use of existential therapy as one of their core practice models or identify with the existential philosophical tradition as their value base. Counselling psychologists, both trainees and experienced practitioners are hopefully validated by the findings of this research to continue to find a fit between the humanistic-existential/phenomenological value-base and the medical model (Cooper, 2009). This includes the professional quest of counselling psychology to be able to ‘speak medical’ while at the same time maintain their identity and focus on the needs and desires of individual clients.

Service delivery

As Gazzola et al (2011) argue, it is more likely that services change the perspective of practitioners, rather than practitioners changing the perspective of medical services. The present study certainly appears to be a powerful example of how practitioners change their perspectives. However, in the wake of movements such as practice-based evidence (Barkham & Mellor-Clark, 2003; Barkham, Hardy, & Mellor-Clark, 2010a; Bower & Gilbody, 2010; Henton, 2012; Mcleod, 2002) it might be worth considering the contribution that both services and practitioners make to client wellbeing, rather than being concerned with one side of this equation only. It might be important to look at services and practitioners in terms of a ‘system’ in which all parts stand in relation to another (Lenihan & Iliffe, 2000; Madison, 2003).

The findings of the current research might encourage those responsible for creating, developing and running services on a day-to-day basis, to consider the relationship between the underlying values and procedures of the primary care environment and those

of practitioners. Recognising that the procedures of primary care, i.e. the strict timeframes, the focus on measurable goals and outcomes and the use of classificatory systems for pathology as well as the values of existential therapy, such as flexibility, client-focus, a focus on the therapeutic relationship, etc. ostensibly all serve a function; and so it might be worth asking how they serve a function for clients. And how this could be improved particularly in an environment such as primary care that is characterised by high diversity both in terms of practitioners and clients.

Recommendations for Clinical Practice & Training

Following from the outlined implications for practice and training (and to a lesser extent service delivery) this research opens a number of avenues for the future.

Firstly, as outlined above, the supervision structure for existential practitioners in primary care and other public sector services might incorporate a more explicit framework for negotiating ‘Givens’ such as the medical culture in primary care. This might mean to explicitly explore practice dilemmas that are related to the practice context and a potential clash in values between practitioners and their context. Thereby, practitioners have a space to find ways of negotiating their expectations, preconceptions and values and the culture, and values of the practice setting.

Secondly, existential practice in time-limited contexts might experiment with a more proactive-interpretative and focussed stance and practitioners might consider supplementing open phenomenological exploration with more focussed strategies e.g. in the way Langdridge (2006) suggests with his solution-focussed way of working. This might be combined with setting and revising therapeutic goals, e.g. through a formal methodology such as the CORE Goal Attainment Form (Barkham, et al, 2010). Further, goal-setting and measurement has been promoted in the literature of psychotherapy (Newton, 2002; Winograd & Shick Tryon, 2011, Rayner & Vitali, 2014) as an individualised way of enquiring into the outcomes of therapeutic working and might support clinicians to accumulate empirical evidence of their work.

Thirdly, the finding that psychometric measures can successfully be used from a phenomenological perspective without necessarily interrupting the therapeutic process might encourage practitioners who want or need to measure their work from a more quantitative empirical perspective to find additional measures that might accomplish both tasks: being useful for clients and being able to produce evidence of the therapeutic work. Margison et al. (2000) for example suggests using case formulations and measures of change (e.g., helpful aspects of therapy, goal setting) as most appropriate measures for the therapist-client dyad.

Fourthly, practitioners in primary care or other public sector settings might need to expand the traditional British existential stance towards ‘de-pathologising’ client concerns to include the reality that systems of psychopathology permeate the public sector. Indeed, a label of pathology is mostly what provides clients with access to psychological therapies. This might mean that practitioners first of all need to make sure that they are fluent in the

language of diagnosis and psychopathology and secondly, that they explore the relevance of diagnosis as part of the therapeutic work.

The findings of this study might also be usefully included into the training of practitioners within academic institutions and placement settings both formally as part of the course content, e.g., teaching curriculum and assignments and more informally as part of placement supervision: training providers might adapt their course content in order to engage students with the subject of how primary care (and potentially also other NHS domains such as secondary care and tertiary care) impact on existential practice. This might take the form of a specific module such as the one offered at the New School of Psychotherapy and Counselling (2016) which offers a ‘Settings and Integration’ module or might be integrated into other modules and clinical supervision. Taking into account the importance that the notion of ‘confidence’ (Category 4) has for trainees in this study, future trainees might benefit from a space to reflect on their practice in the NHS. In turn, this might increase their levels of confidence when practicing in placements. The recommendations for clinical practice outlined above might form the basis for an adaptation of the training curriculum.

Some training institutions such as Regent’s University (2015) already require trainees in counselling psychology to have at least one placement in the NHS and this policy might be usefully expanded to other training institutions and might include a specific requirement to have a placement within primary care. However, it might be important for trainees to gather some practice experience before they are exposed to the demands of primary care, as articulated by some of the participants in this study.

In addition, as outlined above, the grounded theory put forward in this research might form the basis of a practice guideline to primary care which might be developed around the kinds of tensions and practice dilemmas that form part of working in this environment. Rather than a more prescriptive manual however, which might not be acceptable to existential practitioners, this could take the form of a map outlining the kinds of tensions and dilemmas that practitioners might encounter and include the clinical recommendation outlined above, so that practitioners can reflect in a structured way on how these could be managed. Such a guideline could be presented to trainees as part of their placement supervision.

7.4. Recommendations for Future Research

To the author’s knowledge, the current study is the first inquiry into the experiences of existential practitioners in primary care. As such it provides an important initial survey of the landscape that extends in all directions beyond the research question and the subject of this research. It also provides future research with a number of potential starting points, as already discussed in more detail in the relevant previous sections of the previous chapter.

On the other hand raises a number of questions for future research: the presented theory leaves open what contributions practitioners’ ideological positioning i.e., in terms of their

attitude towards the medical model or primary care make to the way they adapt their way of working. For example, are practitioners in this sample particularly biased towards working in the NHS, and what impact might this have on their ability to be responsive in their practice towards the demands of the medical model?

The present study also wonders what the relationship is between what practitioners say they do in this study and what they actually do in practice and what clients' perspectives on this might be. It queries the correlation between practitioners' sense that they successfully work with clients and clients' perspectives on this and it poses the need for a more detailed study of the differences in experiences between novice and established existential practitioners. Moreover, it puts forward the need for a more detailed inquiry into the concepts of 'directiveness', goal-setting and measurement in EPP and the kinds of clients this therapy is useful to. It also raises the question to what extent the tensions and practice dilemmas that existential practitioners encounter in the primary care setup might be translated to other managed care settings. This might also include the question whether these dilemmas are also faced by other practitioners i.e., those that are not existentially trained.

From a counselling psychology perspective, this study further raises questions as to the relationship between practitioners' identity as existential therapists and as counselling psychologists. The later forms a particularly important question, give the extent to which counselling psychology identity forms a contested field of enquiry (Athanasiaides, 2008; Gazzola et al., 2011; Lamproukou, 2014; Lewis & Bor, 2007; Moller, 2011; Mrdjenovich & Moore, 2004). One of the questions raised by this research is whether other counselling psychologists similarly identify so strongly with the existential tradition as opposed to a more pluralistic stance or a stance based on counselling psychology as identity-core or whether this is an artefact of the particular sample.

The central thread throughout these questions is however, a challenge to existential practitioners and researchers to support their work with empirical evidence. Overall, the positive comments that practitioners have made about the research process and the way in which the research interviews contributed to their own reflection, provide evidence that research into existential therapy can be both empowering while at the same time provide 'data' of a more empirical nature that furthers the understanding of the field (Finlay, 2012; Loewenthal, 2011b).

While this study is unable to provide empirical evidence of the effectiveness or efficacy of EPP in primary care and did not aim to gather the kind of data that could argue for this, certainly practitioners perceive their work not only to be possible but also to be beneficial to the clients they work with. This provides a first step to build the evidence necessary to argue for the expansion of existential therapy to the primary care setting e.g., through programmes such as IAPT. Therefore, further research might establish how the processes and outcomes of EPP might be appropriately measured to further contribute to such an argument. This might be established through methodologies such as task analysis (Greenberg, 2007), case studies (Elliott, 2002) and more traditional quantitative methodologies (Bower & Gilbody, 2010) as well as enquiring into the perspectives of clients. Further, even though practitioners in this study did not experience a difference in

the usefulness of EPP for different client groups, it might also be important to enquire into the outcomes of EPP for specific diagnosis, given that most services at primary care level are organised around diagnostic categories.

7.5. Summary

Theoretical literature and anecdotal evidence suggests that existential therapy, both as counselling psychology practice and as psychotherapeutic perspective, provides a good fit with the NHS primary care context, despite a lack of research and official recognition on behalf of the NHS. Indeed, both counselling psychologists and psychotherapists trained in existential therapy are working within this context and primary care also presents an important setting for the training of counselling psychologists.

The outlined research presents the first qualitative study into the actual practice of existential therapy within a NHS primary care context. The focus of the present study was to develop a theory of how existential-phenomenologically orientated practitioners negotiate their professional practice within this setup. Ultimately, the aim was to elucidate practitioners' perceptions of the potential but also the tensions that working in this way presents in order to make a contribution to the existential community. In order to achieve this aim, nine practitioners of varying degrees of experience were interviewed and a theory consisting of four major categories was constructed on the basis of their accounts, using a constructionist grounded theory methodology.

Overall, practitioners are often, at least initially, ambivalent about the demands that the medical model of primary care makes on their practice; *otherness* becomes a strong identity for practitioners and they frequently feel like having to explain their work to both clients and other professionals (including existential therapists). Working to the demands of the medical model often does not present practitioners' preferred way of working. It certainly presents a departure from more 'traditional' or 'purist' ways of working existentially, certainly from a British perspective.

Yet, the grounded theory also suggests that practitioners in this study are able to maintain their existential-phenomenological identity within a primary care context despite initial scepticism. Further, practitioners undergo a learning process which enables them to negotiate the tensions that they are presented with largely successfully, thereby showing that working from an existential-phenomenological perspective in primary care is indeed perceived as both possible and valuable. This forms valuable knowledge for the community of existential practitioners, which is traditionally somewhat reluctant to enter into a dialogue with the medical model. Thereby, the findings of this research also show the importance that practice-based research has in challenging theoretically established viewpoints and to emancipate those practitioners who might not find themselves represented within the established discourse. The findings of this study also call for further research that might eventually support the inclusion of EPP into the officially espoused psychological interventions in primary care.

Moreover, the present theory proposes a framework that maps out the demands that the primary care environment makes on EPP, the challenges and tensions this provides practitioners with, but also the kinds of theories-in-use and practice strategies that practitioners employ to negotiate these. This includes the way in which the limitations in time, the notion of setting and achieving therapeutic goals, the measurement of therapeutic progress and outcomes through the use of psychometric tests, the use of diagnostic categories as well as the impact of differing levels of practitioner experience form part of delivering psychotherapy in primary care. Especially for practitioners in training, novice practitioners but also training institutions this framework might serve as the basis to tackle the lack of practice guidelines that exist in the field of EPP in primary care.

At the same time, the theory developed as part of this research puts forward that, rather than a unified ‘model’ containing particular operational or therapeutic procedures, EPP in primary care might be more faithfully conceptualised in terms of a multi-faceted practice that draws on a plenitude of perspectives integrated by a flexible EP ‘attitude’. Framing EPP in terms of a modality might principally serve the purpose of situating it within the field, rather than describe its practices. Particularly from a counselling psychology perspective, but also from an existential perspective this raises some questions as to how this might link into pluralistic and integrative ways of working, which might be fruitfully explored in future research.

The findings of the present research also pose the importance of paying attention to the shared features of the practice environments beyond the idiosyncratic client-therapist dyad, the latter of which is usually given priority in the existential literature. Thereby, the theory posed here calls for a ‘contextualisation’ of EPP: this might be especially valuable for practitioners in organisational contexts, such as the NHS where there are shared contextual features that have an impact across clinicians and clients. This might support learning and sharing of knowledge beyond the individual therapist-supervisor dyad and therefore beneficial for the community of existential practitioners as a whole.

The results of this research might also have the potential to contribute to contexts beyond primary care. For example, the empirical knowledge developed in this research might find application in other, similar medical-model settings, such as secondary and tertiary care and possibly also in areas where EPP meets with time-limits, the use of psychometric measurement and models of psychopathology; especially as all of these aspects are becoming increasingly prevalent in a funding-driven third-sector (Dickinson, Allen, Alcock, Macmillan, & Glasby, 2012; Hatfield, Ryan, Simpson, & Sharma, 2007; Seaton, 2008). Although further research might need to establish the extent to which a transfer of the findings of this study to other contexts is possible, this study has made an initial significant contribution to establishing the value of EPP in primary care.

8. BIBLIOGRAPHY

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9. APPENDICES

I. Ethical Approval



II. Call for participants

Hi,

I am currently doing a doctorate in counselling psychology at Middlesex University and I am looking to recruit participants for my study. Participation involves taking part in a face to face interview with me and also optionally taking part in a focus group.

My study looks at how psychotherapists and psychologists delivering existential-phenomenological therapy to clients within primary care conceptualise their way of working.

The interviews will give participants an opportunity to reflect on their work in a semi-structured format.

Participants will self-identify as existential-phenomenological practitioners, will have worked in a primary care setting for a minimum of one year and are qualified psychotherapists or psychologists or in the final stages of training of a minimum of 2 years duration.

If you are interested in participating in this study or you know someone else who fits the above criteria, please contact Christian Koebbel on christian.koebbel@nhs.net. Please also find attached the Participants' Information Sheet for further information.

I am happy to participate in any studies you might have and return the favour.

Many thanks in advance,

Christian

The study has received ethical approval from Middlesex University and the New School of Psychotherapy and Counselling, and any data you provide will remain confidential and anonymous. Please find my and my supervisor's details in the attached document.

III. Participants' Information Sheet

Participant Information Sheet Individual Interviews V.2.3



PRACTITIONERS' PERSPECTIVES ON BRIEF EXISTENTIAL- PHENOMENOLOGICAL PSYCHOTHERAPY IN PRIMARY CARE

Research being carried out by **Christian Koebbel** as a
requirement for a **Professional Doctorate in Counselling
Psychology** from NSPC and Middlesex University



1 March 2013

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

What is the purpose of the research?

This study is being carried out as part of my studies at NSPC Ltd and Middlesex University.

Existential-phenomenological approaches to brief psychotherapy (bEPT) are based in existential and phenomenological bodies of knowledge as well as the theory and practice of psychotherapy. However, there are a number of different approaches and few guidelines or frameworks about practicing in environments like primary care.

In order to address the lack on enquiry into bEPT at primary care level, the current study explores qualitatively the perspective of clinicians working in primary care providing bEPT to clients. In order to further substantiate the findings, clinicians providing bEPT in other settings and to populations different from those found in primary care will be interviewed. Thereby, themes and perspectives common to bEPT will be validated and those particular to primary care will be sharpened and possibly contrasted with other settings. Specifically, one of the aims is to sharpen distinctions between specific and non-specific aspects of bEPT at primary care level.

This study supports the position in the literature that advocates for practitioners to be actively involved in intervention development in order to make research findings take account of the 'real-world' practice of bEPT.

Why have I been invited to participate?

You have been invited as you are practicing or have been practicing in the past brief existential-phenomenological psychotherapy within an NHS primary care setting.

Participant Information Sheet Individual Interviews V.2.3

What will happen to me if I take part?**Individual Interview:**

You will be invited to an interview with the me. During this interview you will be asked to discuss a series of open-ended questions. The interview will last approximately 60 minutes. It will take place on the premises of the New School of Psychotherapy and Counselling.

The interview will be audio-recorded. The audio-recording will be transcribed by the researcher and the resulting transcript will be analysed together with other transcripts from other participants using a qualitative research methodology. This method is designed to extract themes from the transcript. If you wish you will be emailed a copy of the transcript of your interview before it is analysed for you to read and edit any information you do not want to be part of the analysis.

For this study there will be interviews with about 6-12 other participants.

Focus Group:

You are also invited to take part in one focus group, which will take place at a date to be arranged once interviews from other participants are collected, transcribed and analysed. During the focus group meeting the findings of the round of individual interviews will be presented to you and you will then be asked to discuss a series of open-ended questions with the other participants who will also be practicing existential psychotherapy. The focus group meeting will last approximately 90 minutes, there will be about 7 other participants who are all practising existential-phenomenological psychotherapy and it will take place on the premises of the New School of Psychotherapy and Counselling. Taking part in the focus group is optional and you can participate in the individual interview even though you decide not to take part in the focus group.

What will you do with the information that I provide?

The individual interview and the focus group meetings will be audio-recorded on a digital recorder, and the files will be transferred to an encrypted USB stick for storage, deleting the files from the recorder. All the information that you provide will be identified only with a project code and stored either on the encrypted USB stick or in a locked filing cabinet at a location with no access to the public.

In the write-up of this research, or any publications that follow, anonymity will be preserved. Identifiable information will be removed or altered sufficiently to protect your identity. Due the relatively small size of the community of existential practitioners anonymity might not be fully guaranteed. You will be given the opportunity to edit information that might identify you and you will be provided with the full transcript of your interviews should you wish to.

The data collected during this research will be kept after I graduate (for a maximum of 5 years), so that I can use it for publications. Audio recordings will be deleted immediately after they are transcribed. All material will be treated as confidential. If this research is published neither your name nor other identifying details are used.

As a professional psychotherapist/psychologist you are aware that you have a duty of confidentiality towards your clients/patients. The participation in this research will not free you from this and therefore any information you share should take this into account. In the event that you happen to share something which is confidential it will be deleted from the transcripts and not included in the analysis of my research.

Participant Information Sheet Individual Interviews V.2.3

Data will be stored according to the Data Protection Act and the Freedom of Information Act.

What are the possible disadvantages of taking part?

The individual interview will be around your practice of brief EPT. Reflecting upon your practice might bring up questions or dilemmas for you and this might be uncomfortable. Even though this possibility might be small it is important that you let me know if you wish to withdraw from the interview.

The discussion in the focus group will also be around your practice of brief EPT. As with any conversation with others who might have differing opinions and where there is the possibility for distressing conversational dynamic to develop, there is a possibility you might be emotionally upset.

Should you tell me something that I am required by law to pass on to a third person (e.g. issues around safeguarding children and issues around terrorism), I will have to do so.

It is acknowledged that there is the potential for us to have been in a previous collegial relationship. Where this might cause you any concerns, these will be addressed prior to the interview. Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decided to take part you may withdraw at any time without giving a reason.

I will endeavour to be sensitive to potential previous collegial relationships between us at all times.

What are the possible advantages of taking part?

Being interviewed about your experience of bEPT does not have any direct benefits apart from providing you with a space to reflect about your practice. Some people might find this beneficial. Your participation will also contribute to the development of the field of existential-phenomenological psychotherapy in primary care settings.

Consent

You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign the attached consent form before the study begins.

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decided to take part you may withdraw at any time without giving a reason. If you are currently employed within the NHS your decision to participate will not affect your employment contract.

As the topics discussed during the interview and also the focus group are open ended I cannot entirely foresee the nature of the ensuing discussions. Therefore, I will ask you to renew your consent to participate at the end of the individual interview and also at the beginning and end of the focus group should you decide to participate.

Who is organising and funding this research?

This research forms part of my doctoral degree in Counselling Psychology at the New School of Psychotherapy and Counselling and Middlesex University. It is self-funded.

Participant Information Sheet Individual Interviews V.2.3

Expenses:

I am happy to reimburse you for the costs of your transport for attending the interview or focus group.

Who has reviewed this study?

All proposals for research with human participants are reviewed by an Ethics Committee before they can proceed. The New School of Psychotherapy and Counselling research ethics sub-committee have approved this.

Thank you for reading this information sheet. If you have any questions you can contact me at:

Christian Koebbel
NSPC Ltd.
258 Belsize Road
London NW6 4BT
Email: christian.koebbel@nhs.net

If you have any concerns about the conduct of the study, you may contact my supervisor:

Patricia Bonnici
NSPC Ltd.
258 Belsize Road
London NW6 4BT
Email: pbonnici@gmail.com

Or

The principal
NSPC Ltd.
258 Belsize Road
London NW6 4BT
Email: admin@nspc.org.uk
Tel: 020 7624 0471

IV. Consent Form

Participant Consent Form Individual Interview V2.3



NSPC Ltd
258 Belsize Road
London NW6 4BT

Participant Consent Form

Practitioners' Perspectives on Brief Existential-Phenomenological
Psychotherapy in Primary Care

Christian Koebbel
Chief Investigator/Doctoral Student
christian.koebbel@nhs.net



**Middlesex
University**

Middlesex University
The Burroughs
London NW4 4BT

The research is being conducted to collect data for a research dissertation and in partial fulfillment of the degree of DCPsych in Counselling Psychology at the New School of Psychotherapy and Counselling and Middlesex University

Please initial in the box:

1. I confirm that I have read and understood the information sheet dated 1 March 2013 (Version 2.3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. ☐
3. For purposes of the research, I understand that an interview will be conducted with me and tape-recorded. All recordings will be kept entirely confidential and destroyed following research completion. ☐
4. I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur. ☐
5. I agree to take part in the above study. ☐

Please initial here if you would like to receive information regarding the findings of this study. Please note, in order for this to be possible we will need to keep your address on file, which we would not do otherwise. ☐

Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits ☐

I have read and understand the above information and agree to participate in the research

Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature
_____	_____	_____

V. Interview Debriefing Form

Debriefing Interview V.2.1



PRACTITIONERS' PERSPECTIVES ON BRIEF EXISTENTIAL-PHENOMENOLOGICAL PSYCHOTHERAPY IN PRIMARY CARE

Research being carried out by **Christian Koebbel** as a
requirement for a **Professional Doctorate in Counselling
Psychology** from NSPC and Middlesex University



Middlesex University
The Burroughs
London NW4 4BT

Debriefing Letter

1 March 2013

Thank you for having taken part in this research!

Your efforts are very much appreciated and make a valuable contribution to existential-phenomenological psychotherapy at primary care level.

Should you have any concerns following this interview please ask me. Issues that arise from this research can be discussed with your clinical supervisor or personal psychotherapist. If you are not in supervision/psychotherapy you might find the following sites useful to find a therapist/supervisor:

- <http://www.itsgoodtotalk.org.uk>
- <http://members.psychotherapy.org.uk/find-a-therapist>

You can find a psychologist via the following website:

- <http://www.bps.org.uk/psychology-public/find-psychologist/find-psychologist>

Alternatively, you can speak to your GP for further advice and support.

Your information will now be kept until publication of the research and will remain confidential. When the research is published I will make sure that neither your name nor other identifying details are used.

You can contact me at:

Christian Koebbel
NSPC Ltd.
258 Belsize Road
London NW6 4BT
Email: christian.koebbel@nhs.net

If you have any concerns about the conduct of the study, you may contact my supervisor:

Patricia Bonnici
NSPC Ltd.
258 Belsize Road
London NW6 4BT
pbonnici@gmail.com

Or

The principal
NSPC Ltd.
258 Belsize Road
London NW6 4BT
Email: admin@nspc.org.uk
Tel: 020 7624 0471

VI. Interview Schedule

Interview Schedule V2.1

Introduction

Before we start the interview, can you tell me some brief demographic information? Age & gender.

From this interview I would like to learn more about your experience of working existential-phenomenologically. Particularly, I would like to learn how you work in this way within the context of Primary Care.

I will start off with some more general questions and then we have some time to talk about more specific topics and what comes up from our conversation.

I am not going to ask you about particular clinical cases in order to help us preserve the confidentiality of your clients but please do draw on your clinical experience and clients in your answers.

Questions

1. Can you very briefly outline your qualifications/stage of training? (3min)
 - a. How long have you worked as a therapist/in primary care?
 - b. Have you trained in another modality apart from EPP?
2. Please tell me a little bit about the primary care context you work/have worked in and about the structure of your work there. This is more to get an idea of the setup of your work, rather than about your experience there. We will get to your experience in a minute.
 - a. How long have you worked there?
 - b. What is the setup you work in?
 - c. Where do you get your referrals from? How is it decided that you get a particular referral?
 - d. Session numbers?
 - e. How you use the space in between sessions? Homework?

Ok, now I would like to talk specifically about your existential-phenomenological work in this setting.

3. What is existential-phenomenological about your work?
 - a. Can you give me some details about how you work in this way with clients?
 - i. Is there a session/treatment structure (is that important for your work?)?
 - ii. What do you do each session?
 - iii. How do you set the aims for your work and how do you follow-up on them?
 - iv. Are you using measures? What is your experience of those?
4. How do you feel your work is helpful to clients?
 - a. What is particularly helpful?
 - b. Any particular client-type that your work is particularly helpful to?
 - c. Any particular client-type that your work is not helpful to?
5. What is particular to Primary Care in your work?
 - a. Are there any tensions between your work and PC/managed care/the NHS?
6. Do you think there are benefits from formalising or systematising the way you work? For example in the form of a clinical guideline, or an overview of the possible content of the individual sessions. If so, how could this be accomplished?

- a. Which elements could be formalised? How?

Additional questions:

1. What is the role of the therapist?
2. Time and limitations of time?

Debriefing

I have no further questions. Have you got anything else to say? What was your experience of this interview? Do you think you have been able to represent your experience of EPP in PC accurately?

— Questions I hold in mind and might ask if the interviewee does not bring up the topic.

Interview Schedule V3.0

Introduction

Before we start the interview, can you tell me some brief demographic information?

- 1) Age & gender
- 2) Can you very briefly outline your qualifications/stage of training?
- 3) How long have you worked as a therapist and as a practitioner in primary care?
- 4) Other experiences in NHS/other services?

From this interview I would like to learn more about your experience of working existential-phenomenologically. Particularly, I would like to learn how you work in this way within the context of Primary Care.

I will start off with some more general questions and then we have some time to talk about more specific topics and what comes up from our conversation.

I am not going to ask you about particular clinical cases in order to help us preserve the confidentiality of your clients but please do draw on your clinical experience and clients in your answers.

Questions

- 1) What is the setup you work in? (Session numbers, referrals, physical setup)
 - What is it like to work existential-phenomenologically in primary care?
 - Are there any tensions between your work and the setup?
 - How do you negotiate these?
- 2) What is the contribution of existential-phenomenological theory/practice to your work in primary care?
 - Do you integrate other approaches to psychotherapeutic working into your work?
 - What is particular to primary care in your work?
 - Can you compare your work to work you might have done in other settings?
 - Is the difference between primary care and other NHS setups significant for your work?
- 3) I am interested in the delineation between you as a person, you as a therapist and you as a primary care practitioner, can you say something about that?
 - How do you manage these aspects/identities?
 - How do you manage the emphasis that BEPP places on freedom and clinician responsibility?
- 4) What is it like to represent your way of working to others (i.e. to clients, GPs, other professionals)
 - How do you represent your work to others? What would help you to do that better?
 - Do you find that clients have particular expectations of therapy? How do you work with those?
- 5) To what extent did your perspective on your work change over the time you were working in primary care?
 - To what extent is this linked to being a trainee and learning to do psychotherapy?
- 6) If you are not currently working in primary care, have you considered employment in primary care / going back to primary care?
- 7) What is it like to reflect on your practice in primary care?

Debriefing

I have no further questions. Have you got anything else to say? What was your experience of this interview? Do you think you have been able to represent your experience of EPP in PC accurately?

— *Questions I hold in mind and might ask if the interviewee does not bring up the topic.*

Interview Schedule V3.1

Introduction

Before we start the interview, can you tell me some brief demographic information?

- 1) Age & gender
- 2) Can you very briefly outline your qualifications/stage of training?
- 3) How long have you worked as a therapist and as a practitioner in primary care?
- 4) Other experiences in NHS/other services?

From this interview I would like to learn more about your experience of working existential-phenomenologically. Particularly, I would like to learn how you work in this way within the context of Primary Care.

I will start off with some more general questions and then we have some time to talk about more specific topics and what comes up from our conversation.

I am not going to ask you about particular clinical cases in order to help us preserve the confidentiality of your clients but please do draw on your clinical experience and clients in your answers.

Questions

- 1) What is the setup you work in? (Session numbers, referrals, physical setup)
 - What is it like to work existential-phenomenologically in primary care?
 - Are there any tensions between your work and the the setup?
 - How do you negotiate these?
- 2) What is the contribution of existential-phenomenological theory/practice to your work in primary care?
 - Do you integrate other approaches to psychotherapeutic working into your work?
 - What is particular to primary care in your work?
 - What do you find challenging about your work? (Have you ever had doubts about the way you work?)
 - Can you compare your work to work you might have done in other settings?
 - Is the difference between primary care and other NHS setups significant for your work?
- 3) I am interested in the delineation between you as a person, you as a therapist and you as a primary care practitioner, can you say something about that?
 - How do you manage these aspects/identities?
 - How do you manage the emphasis that bEPP places on freedom and clinician responsibility?
- 4) What is it like to represent your way of working to others (i.e. to clients, GPs, other professionals)
 - How do you represent your work to others? How do you manage the sense of not being understood in your way of working? What would help you to do that better?
 - Do you find that clients have particular expectations of therapy? How do you work with those?
- 5) To what extent did your perspective on your work change over the time you were working in primary care?
 - To what extent is this linked to being a trainee and learning to do psychotherapy?

- 6) If you are not currently working in primary care, have you considered employment in primary care / going back to primary care? How come you haven't gone back?
- 7) What is it like to reflect on your practice in primary care?

Debriefing

I have no further questions. Have you got anything else to say? What was your experience of this interview? Do you think you have been able to represent your experience of EPP in PC accurately

— *Questions I hold in mind and might ask if the interviewee does not bring up the topic.*

VII. Member Check

Member Check: Instructions

Hi,

Thank you very much for agreeing to take part in the focus group/interview for my study.

I have attached a summary of the findings of my research. In order to have a starting point for the conversation within the focus group/interview it would be helpful if you could do the following:

1. Please read through the attached document before we meet.
2. Please **highlight those sections** of the findings that you feel are congruent with your own experience.
3. Please underline those sections of the findings that you feel might not correspond with your experience.
4. Please take a moment to think about or to write down any aspects of your experience of working from an existential-phenomenological perspective in primary care that you feel are not covered in the attached findings.

During the focus group you will also have an opportunity to feed back your experiences to the group.

*Member Check: Summary of Analysis***Practitioners' Experience of Practicing EPP in Primary care***Summary of the findings***1. Introduction**

This Grounded Theory of existential-phenomenological practice in primary care describes how interviewees adapt their practice to the primary care environment. One of the central threads that runs through the analysis of the collected data revolves around practitioners' experience of 'otherness', that is navigating a fit between the setting of primary care, the existential-phenomenological therapeutic tradition and the practitioner's own way of practicing. This presents as a number of tensions and practice dilemmas but also involves learning and developing for the practitioners. Practitioners are often initially sceptical about working in primary care but overall find ways of practicing within this setting.

2. Primary care

The most important aspect that defines the primary care environment is primary care's rootedness in the medical model. This medical way of working is contrasted with an existential-phenomenological perspective. Working in an environment that is dominated by medical vocabulary and medical practices and procedures is problematised as it results in a number of tensions and clashes. When talking about their practice, interviewed practitioners often make reference to a need of making their work intelligible, of having to explain, articulate and at times even defend and justify their way of working and their role within the setup to their clients, GPs and other professionals, including their supervisors.

There is a sense across the interviews that practitioners identify as existential-phenomenological therapists over the identity of being primary care clinicians, or indeed over being psychotherapists and counselling psychologists.

3. Existential-phenomenological practice**3.1 Existential-phenomenological practice in primary care as model**

Practitioners talk about existential/phenomenological therapy as a comprehensive 'model' or an 'approach'. This model of therapy is also construed to address somewhat different aspects of clients' concerns than other therapeutic models (especially CBT) as its emphasis lies on helping clients understand how their stance impacts on their experience of their concerns, rather than solving their problems or reducing symptoms of mental illness.

However, when analysing more detailed descriptions of differences to other psychotherapeutic ways of working, the data suggests that practitioners are unsure about where they would place a line of delineation. Furthermore, it becomes clear that framing EPP as a systematic and internally consistent therapeutic model, serves the function of setting it apart from other perspectives: it appears as a way to establish practitioners' identity in an environment that is perceived as alien and sometimes hostile.

3.2 EPP as a tapestry of practices

In practice EPP forms a rich and diverse body of idiosyncratic practices:

EPP as multi-faceted practice

EPP is influenced by a great number of sources and therefore EPP is not seen as monolithic or unified but rather as flexible and responsive to the particular context. The idiosyncratic meeting of the practitioner with a particular client at a particular point in time is framed as taking precedence over theoretical concepts. Indeed, rather than providing an a priori prescriptive framework, philosophy “backs up” the particular way of practicing.

Role of the therapist: Self-As-Therapist

Practitioners frequently describe the use of their subjective experience as a guide within therapy. The sense of self of the person who is working as a therapist is constructed as a fundamental part of the therapeutic model. The self-as-therapist at times becomes inseparable from the existential-phenomenological therapeutic model it is grounded in.

Attitude

EPP in primary care is often framed in terms of an ‘attitude’ towards therapeutic working. This attitude allows for the flexible integration of a wide variety of existential and philosophical concepts and approaches, as well as the integration of the therapist-as-self into the therapy through a watchful, critical and curious stance on the phenomena that emerge within the therapy context. Interestingly, this integration is restricted to existential-phenomenological concepts and with only one exception, none of the practitioners talks about integrating psychotherapeutic tools, strategies or metaphors from other modalities though the delineation between what is ‘existential’ and what is not remains vague.

Freedom and Choice

This way of practicing is frequently linked to providing freedom and practitioner choice against rigidly operationalised professional procedures and values in a primary care

context. At the same time, this choice gives rise to anxiety as to their own role as facilitator of therapeutic change, particularly in the urgency of time-limited contexts. Several practitioners talk about how to negotiate the ‘vastness’ of possible ways of approaching client concerns against a professional context which requires clearly reasoned responses and decisions. When I followed this up directly, most practitioners, said that they would have found guidelines or an articulated framework useful for being trainees within primary care in terms of containing some of their anxieties.

4. Learning to work with primary care

Initially, many of the interviewed clinicians are sceptical whether they would be able to successfully practice in primary care, particularly those whose work in primary care forms a placement early on in their training. However, practitioners uniformly describe a number of processes of learning, adapting and development that allow them to practice in this setting. Most practitioners voice positive experiences working in primary care and many would consider going back to work there although only one of the interviewed practitioners currently works in primary care.

4.1 Limitations of time & brief work

Especially for trainees brief existential-phenomenological practice is often characterised as deviating from the ‘norm’ of existential-phenomenological practice as an open-ended, time-unlimited approach. The great majority of practitioners, explicitly talk about how their initial reservations underwent a shift. This shift is characterised by re-framing the limitation in time, by accepting it as an unchangeable feature of the setup, as a “Given’.

Working Directively

Clinicians describe a faster pace compared to their experience in longer-term settings. Working in the short-term therefore might mean to pick up themes or patterns within client material quicker, rather than allowing them to emerge more slowly.

Secondly, short-term therapy is constructed to put more emphasis on the practitioner to make decisions. Brief EPP is construed as somewhat less phenomenological in the sense of emphasising less the horizontalisation and non-hierarchical exploration of experience but rather aware of the fact that, as one practitioner puts it: “clearly some things are more important than others”.

Finally, working directly in a short-term context means to be more selective about what aspects of the client presentation to work with. Practitioners represent this process as being therapeutically useful as it helps to find out what is important for the client, thereby clarifying their concerns into a more complete perspective. At the same time, practitioners also often recount a frustration of being presented with a very rich and complex clinical picture and having to neglect certain aspects and emphasis others.

Interestingly, brief EPP was at no point construed as being in any way less useful than long(er) term psychotherapy. Treatment length as such is not seen as having an ideal

session number, indeed some of practitioners' explicit learning within a primary care context is that significant moments or idiosyncratic therapeutic processes can be more relevant to the therapeutic outcomes than a certain number of sessions.

4.2 Measures as a phenomenological tool

A number of practitioners allude to being sceptical towards psychometric measures at the beginning of their work in primary care as they uniformly see the use of psychometric measures to establish psychopathology, to benchmark performance and client progress as antithetic to existential-phenomenological practice. Notably, practitioners' perspectives undergo a shift throughout their work in this setting that enables them to work with their ambivalence rather than feel limited by it. Practitioners talk about suspending their disbelief, that is to bracket their own presumptions of the nature and effect of 'forms' and accept them as a given in the context of primary care. As a result the way in which forms are used is described by practitioners mostly in terms of a way of orienting the work with their clients and as a way to give a focus to some phenomena as opposed to others and therefore gain a starting point or a signpost for the direction in which to guide the therapeutic work. At the same time, this does not mean that this is the practitioner's preferred way of working.

4.3 Pathology and vulnerability

On one hand, practitioners are very clear that they understand psychopathology and diagnostic categories as reductive labels that stand in opposition to existential-phenomenological thinking, on the other hand they find them to be an intrinsic part of the primary care environment. Holding 'lightly' the emphasis on pathology in primary care, that is bracketing the meaning that practitioners ascribe to the medical model of pathology allows them to engage it: it allows them to hear and work with the meanings that clients attach to their diagnosis. Most practitioners mention that they take some time to understand the diagnosis of a client as a label with them and try and uncover what that means for them as a person. They point out the usefulness of diagnostic labels as a starting point for exploration in the sense that it gives both client and practitioner a starting point within the vast and often confusing concerns that clients bring with them. At the same time, practitioners challenge assumptions of vulnerability or being 'dysfunctional' that are attached to certain diagnoses.

4.4 Goals & Outcomes

Practitioners make frequent references to working in an environment that places emphasis on concrete and measurable therapeutic outcomes. Practitioners find clients often have expectations to 'get rid of' problems, through initially set goals towards a 'solution' and this is often problematised in practitioners' accounts as narrowing and limiting the therapeutic work.

Acknowledgment and acceptance of clients' expectations and the 'solution focus' espoused by GPs and the medical model presents a reconciliatory aspect in practitioners' work: one of the ways of working with clients' expectations is to spend a proportion of therapy realigning the reason for referral with the client's own experience.

Existential-phenomenological practitioners emphasise the notion of therapeutic goals as a loose framework that gives the therapy process some direction. Central to this is a conception that it is not particular goals that carry importance, but rather the process of setting out aims and working with them and particularly the relationship towards this process carries importance.

It is practitioners' experience that, even though there might be some initial aims and objectives, often in line with the reason for referral given by the referrer, the exploration of clients' concerns change the focus of what clients want and their appreciation of their initial presenting concerns.

Therapeutic Outcomes

Practitioners put forward a wide range of examples how therapy is useful, helpful or meaningful across several clients. However, practitioners do not tend to generalise beyond particular encounters towards the more general types of outcomes which existential-phenomenological practice might elicit as this does not seem to be important to their practice with clients. However, some practitioners seem to search for ways in which they can talk about and articulate their practice in a way that encapsulates not only particular examples but gives a broader sense of how they work in order to defend the value and utility of the therapeutic practice.

5. Experiences as trainee

The tensions that trainees are presented with emerge around two delineated but related aspects: firstly, trainees' learning process requires them to strike a balance between exploring clients' concerns 'phenomenologically' and being 'directive', 'challenging' and proactively offer their clinical expertise in the urgency created by the short-term context. Secondly, trainees experience a need to assert their 'otherness' and their existential-phenomenological practice in the face of a pressure to 'fit in' with primary care. Particularly the process of developing 'confidence' is shared among practitioners to describe managing the pressure they feel placed upon them. However, talk about confidence and the use of overtly emotive language is mainly restricted to female practitioners.

Notably, none of the trainees question their commitment to existential-phenomenological practice. Surprisingly, trainee practitioners do not feel they work differently to how they work once they are qualified, rather they describe a heightened sensibility to the tensions they experience.

Guideline to EPP in primary care

Trainee practitioners talk about potentially finding validation of their practice and containment of anxieties in a clearer formulation of EPP in terms of a more systematic model, structured guidelines, manuals, or frameworks. The concrete shape of such a model is uniformly construed to contain general principles of working existential-phenomenologically, the outline of possible conflicts and areas that form an important part of this kind of work. At the same time trainee practitioners are concerned with maintaining the freedom to work in an individual manner with each client and reject the notion of working to a pre-defined structure.

Member Check: Analysis

Practitioners' Experience of Practicing EPP in Primary care

Summary of the findings

1. Introduction

This Grounded Theory of existential-phenomenological practice in primary care describes how interviewees adapt their practice to the primary care environment. One of the central threads that runs through the analysis of the collected data revolves around practitioners' *experience of 'otherness'*, that is navigating a fit between the setting of primary care, the existential-phenomenological therapeutic tradition and the practitioner's own way of practicing. This presents as a number of tensions and practice dilemmas but also involves learning and developing for the practitioners. Practitioners are often *initially sceptical about working in primary care* but overall find ways of practicing within this setting.

2. Primary care

The most important aspect that defines the primary care environment is primary care's rootedness in the medical model. This medical way of working is contrasted with an existential-phenomenological perspective. Working in an environment that is dominated by medical vocabulary and medical practices and procedures is *problematised as it results in a number of tensions and clashes*. When talking about their practice, interviewed practitioners often make reference to a need of making their work intelligible, of having to explain, articulate *and at times even defend and justify their way of working and their role within the setup to their clients, GPs and other professionals, including their supervisors*. *There is a sense across the interviews that practitioners identify as existential-phenomenological therapists over the identity of being primary care clinicians, or indeed over being psychotherapists and counselling psychologists.*

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of their concerns, rather than solving their problems or reducing symptoms of mental illness.

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therapeutic change, particularly in the urgency of time-limited contexts. Several practitioners talk about how to negotiate the ‘vastness’ of possible ways of approaching client concerns against a professional context which requires clearly reasoned responses and decisions. When I followed this up directly, most practitioners, said that they would have found guidelines or an articulated framework useful for being trainees within primary care in terms of containing some of their anxieties.

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Comments: I feel that this summary of analysis, on the whole, reflects my experience of being an EPP in Primary Care. I don't feel that there is anything which has been left out.

Highlighted sections: findings that participants agree with/feel are congruent with their own experience.

Underlined, *italicised* and **bold** sections: findings that participants feel do not correspond with their experience

VIII. Sample Interview Transcript

Time	Speaker	Content
0:00.0 - 3:06.4		Introduction, collecting participant demographics.
3:06.4 - 3:12.1	Christian	Do you want to talk me through the sort of setup of the primary care setting where you worked?
3:12.1 - 3:20.6	Tony	So, yeah, so when you say context, where you referring to the setup there?
3:20.6 - 3:24.9	Christian	Yeah.
3:24.9 - 3:26.9	Tony	The more mechanics of the place..
3:26.8 - 3:33.0	Christian	Maybe give us a brief idea of what...
3:32.9 - 5:01.5	Tony	..a picture.. So, I was in a GP surgery, uhm, and I actually used one of the rooms that was occupied by one of the GPs, uhm, obviously when they weren't there. Uhm, so the actual setup in itself was quite different anyway because it was an office, sort of two office chairs next to each other rather than more of a setup for therapy. Uhm, and obviously being in a GP surgery it has a slightly different atmosphere to, for the fact that people are turning up, I think people are more used to turning up to a GP surgery to go and see a GP, for a medical issue as opposed to uhm, sort of psychotherapy or counselling, as sort of non-medical intervention. So, I think that's sort of, it adds something to the atmosphere or intention of both the client and I felt a little bit also as a therapist. Certainly it had an impact on me as a therapist.
5:01.6 - 5:18.5	Christian	Yeah, I guess that'll be interesting for me to talk a little bit about what it was like for you to practice there. Or what it was like for you to practice in an existential phenomenological way there.
5:18.6 - 7:01.8	Tony	Well, I suppose it was to be, I felt it was necessary for me to be quite mindful of the setting in terms of what the expectations may have been of the clients. Uhm, because there was an assumption that they were seeing a kind of medical person there, a doctor of sorts. And, which sets up expectations and medicalises what I am doing, even though this is even before they've met me. In their mind. Uhm, in the mind of the client I think because it's a context thing. So, that, that was something that I felt I had to be quite mindful of and when I heard it, or it, there was an inference of it within the client material I might check out with them what their assumptions where of therapy or of counselling, but that would often come up because as probably a part of me just trying to find out a little bit more about them in the usual session I'd find out what their experience was of therapy or counselling in the past. And that'd give me an opportunity to maybe clarify my own position as a therapist.

Time	Speaker	Content
7:01.7 - 7:09.2	Christian	How did you work with those sort of experiences, uhm expectations of clients? How do you sort of negotiate that, I guess?
7:09.2 - 8:33.9	Tony	Uhm, I found it, I did find [3s] I didn't find it always that easy because in a sense, uhm it was immediately bringing up an anxiety for the client. Uhm, about who, who am I seeing? If, if I am not going to get a diagnosis of be given a sort of care plan, some sort of cure. As might be expected in a place like that. Then what am I getting? Who is this person? Which obviously then for me was sort of a pressure to justify who am I and what is my role within this context. Which I didn't really need to go into with them but it was something that I noticed myself. And at times clients, did ask, what are you, who are you if you are not going to give me a diagnosis.
8:33.9 - 8:43.1	Christian	And how does that stand in relation to your sort of existential practice, or existential-phenomenological practice of yours?
8:43.1 - 9:58.7	Tony	Uhm, in terms of understanding my position within the relationship, uhm, uhm, I's pose it was to kind of to challenge the assumption that I somehow was an expert at being human or something. Uhm, or dealing with human issues. And there was an expectations that I should have answers of how to deal with human issues or issues of existence. And so my, or around being, so my uhm, so I suppose it was to ask questions really, not necessarily to deflect, but actually I knew that my answering a direct question of theirs was really playing into another dynamic of reassurance and avoidance really of the issues. So, yeah I had to be just kind of mindful about that.
9:58.7 - 10:03.1	Christian	So there is a particular way in which you were working..
10:03.1 - 10:23.3	Tony	So, it was, so it would be trying to encourage the client to reflect on their own experiences that they were coming to counselling for. Uhm, to discuss what they believed was their difficulty and get them to orientated them around and familiarise themselves with their perceived difficulties and struggles. Uhm, in a way, uhm trying to get them to think in a different way or get a new perspective what to them seemed very familiar but actually not necessarily well explored.
10:57.4 - 11:16.2	Christian	And you sort of alluded before, you talked about existential therapy on one had and a sort of medical perspective on the other hand. So, what was sort of your experience of that?

Time	Speaker	Content
11:16.2 - 13:02.2	Tony	So, I suppose the challenge there, is within a sort of culture of diagnosis and cure which I think exists in, in GP surgeries and hospitals, primary, secondary care is uhm, so for me, so I suppose the difficulty for me is I don't, I am aware that I don't know any cures. Uhm, I don't see myself as an expert on life. But there, I have a certain skill in asking questions and a way of being with clients uhm which actually is another part of what I do, which is I suppose to break down the hierarchy or the power dynamic in the therapeutic relationship to make us more equals in a sort of I-Thou type way of relating. Rather than sort of doctor-patient or indeed, any of that sort of power dynamic that comes in. So, that's a conscious thing that I would make an effort to do. Really to demonstrate a way of being, that this relationship is different to one of doctor-patient. Even though it's the same room that they might see the doctor in.
13:02.1 - 13:06.7	Christian	And that's sort of particular to primary care?
13:06.7 - 13:13.2	Tony	Yeah, yeah, I think that's very particular to primary care!
13:13.1 - 13:26.9	Christian	And are there any other tensions, because I am wondering whether that's maybe what we are talking about: a sort of tension between a medical and a more sort of existential way...
13:27.0 - 14:18.7	Tony	Yeah, there is certain protocols within the primary care setting which would have to be filled anyway. I think which challenge a phenomenological way of being, because understanding client material, because ultimately the context requires you to uhm, write notes and reports, certain bits of information that is commonly understood by the wider, sort of by the GP or other health care professionals. So, then you have to buy into a use of language that is commonly understood.
14:18.7 - 14:20.4	Christian	How was that for you?
14:20.4 - 15:19.7	Tony	Uhm, I found it, again, challenging, 'cause I felt that the words could be either misinterpreted or I might be using them wrong. It's neither anyone's fault, but the difficulties with language and how it's interpreted. Uhm, and you have to put down very sort of factual notes, uhm, and again coming from a position of questioning and uhm, uncertainty to then have to write factual statements can be quite difficult.
15:19.8 - 15:20.5	Christian	How did you sort of manage that difficulty?

Time	Speaker	Content
15:20.4 - 17:06.3	Tony	I just tended to use language that I was, trying got keep it as simple and factual as I could, in terms of possibly saying: the client told me. Uhm, and then trying to use the word that they had used or something if it was relevant. Really so that I was just reporting something as opposed to giving any sense of what the client might be experiencing or what my experience of the client was. It's the difference I suppose between doing process notes and clinical note taking for others to read. And then we had other forms like PHQ-9, GAD-7 which again you have to report the scores and things, that's fine I don't mind doing that for the sake of fulfilling criteria but I would question the validity...well no actually I think, I think they are all perfectly valid the forms but they, again it would have to be taken into account that they are not the be all and end all of answering all the questions, of addressing the individual.
17:06.3 - 17:14.0	Christian	And what, how did you sort of work with that with clients?
17:14.1 - 18:15.8	Tony	Uhm, so I would get them to fill the forms out and I would always ask them afterwards how it felt filling forms out. Because I was quite interested how they responded to them, some felt it was very helpful to direct their thoughts and others found it really aggravating and irrelevant because they didn't feel it addressed them at all. As individuals or didn't resonate with their experience. So, uhm, you know it reveals information about the client and so I thought it was useful in that. It starts a dialogue of some sort. But, I think it also does slightly help to uhm, then reaffirm the client that they are in a medical context.
18:15.8 - 18:33.0	Christian	What do you think, is the contribution of existential-phenomenological theory or practice to the work you were doing in primary care?

Time	Speaker	Content
18:33.0 - 20:56.8	Tony	Well, for me context, from an existential perspective context is essential. Because everything has a context. And that's why I think existential therapy can be taken into primary care because it's just another context. And I think the fact that it's time-limited in a way that uhm primary care demands. Again it might not necessarily make it, I don't, I think it's a case of what you are used to working in in terms of number of sessions, short-term, long-term, ongoing. It will all have an impact on the work and the pace of the work and quite often what I would find is that initially a client would come with a, tell me about themselves and their situation and we would have to uhm, kind of both quite consciously agree on areas we might not be able to explore. And allow the client to chose what areas they feel they need to explore. So, it would be very much up to them to decide what the focus of the work would be. Uhm, but we're also kind of consciously aware of what we are leaving out. And at times we would have to make cross-reference to those points across the work, across the sessions. So that's obviously, I think it can be, it can be a frustration not always feeling like you have enough time but then, that's again reflects, not only the existential position, because we are in a time-limited context in our own existence anyway, so you can quite often draw those parallels of how we priorities and chose what we chose to do in life, what's important to us in life.
20:56.8 - 21:02.6	Christian	Did you integrate any other sort of psychotherapeutic ways of working into your work?
21:02.5 - 23:15.6	Tony	Well, uhm, there's some ideas around... yes is the answer because I, because it was a part of my training anyway so I am interested in the history and the context of the client anyway. So, I, I have ideas around attachment theory that I am interested in that will certainly uhm, in a short term context that might direct some of my questions a bit more. Uhm, so again, I think because of the time I probably have then a little bit more direction in my questioning. Rather than just phenomenological, I think I was less phenomenological in that setting. Uhm, in my questioning, we'd have to consciously focusing on what we are doing so by that we automatically, things like the idea of horizontalisation, uhm of issues, you can't really afford, I felt you can't really afford to do that. Because there were clearly things that were of more importance than others. To the individual. And it was a responsibility of working within that setting uhm, where you have to account for uhm, some of the care you are taken of the clients. And the responsibility of keeping them safe and things. Which you buy into in that context. Which means you have to address various issues with more priority.
23:15.5 - 23:17.3	Christian	So there is more of an interpretation in that sense?

Time	Speaker	Content
23:17.3 - 23:25.6	Tony	Yeah, there is. There is more of an interpretation.
23:25.6 - 23:47.9	Christian	Hmm, uhm if you were to compare your work in primary care to other settings that you have worked in or other NHS settings, uhm, what would you say?
23:47.9 - 26:34.8	Tony	Uhm, well I'spose overall in NHS settings generally, let's say compared to private practice there is a duty of care that is, that is everywhere. And accountability, uhm, it's, it's such a part of the culture it seems to definitively have it's own influence on the work, because you have to ask questions during assessment, the other thing is you are doing assessments at the beginning to find out some very direct things about the clients and things, so it's very directive in that sense but you need to check out things like suicidality and any kind of risk issue like that which I don't necessarily think, you might listen out for them uhm, to ask them directly as a kind of almost routine that doesn't really attend to the individual in front of you, it's just, that's for a different pair of ears or some other kind of accountability things. Uhm, yeah. I mean that's to say, I mean that goes with primary care and all NHS settings, uhm, when I've worked in secondary care, things like the rooms are set up uhm more appropriately for therapy I'd say. I's ay there was more privacy and the clients felt that there was more anonymity for them because uhm, where at the GP's, they might know the GPs, they might know the receptionist, other people in the local waiting room, whereas when you go into hospital there are many different reason why you might be going there and it's I think they just felt a bit....
26:34.8 - 26:42.0	Christian	So there is a difference in setup. Did you experience yourself working differently in between different NHS setups?
26:42.0 - 27:39.3	Tony	Yes, because again, because of the time, amount of sessions we were offering was different, I was offering more sessions in secondary care, uhm I think there was a sense from those who had experience of therapy or counselling previously uhm, and had had offered more sessions in the past, felt that six sessions in primary care felt a bit light weight. Maybe they weren't taken as seriously. Whereas the ones, people who were referred to the hospital uhm, setting felt it was taken a bit more seriously, it was a bit more care involved, it was a bit more formal.
27:39.3 - 27:41.7	Christian	How did you manage those differences or how did you negotiate them in your way of working?

Time	Speaker	Content
27:41.6 - 28:33.8	Tony	Well, I suppose, it felt like there was just less, from a time perspective it felt like there was less pressure, I could be more phenomenological, I could give, I could allow the client more space to explore their own process, their own reflections, their own material. Uhm, which was, which was very helpful. Uhm, but in other terms it didn't really impact, I mean the way I was working I still viewed or heard the material in the same way.
28:33.9 - 28:47.2	Christian	So, the setup and the number of sessions and that, is impacting on the way you work. Uhm, not the other way round almost?
28:47.2 - 28:57.0	Tony	Yeah, yeah I would say so. Uhm, yeah.
28:57.0 - 29:20.9	Christian	Uhm, [5s] is there anything that you found particularly challenging to your work in primary care? We sort of touched on this before in a way, I don't know if there is anything to add?
29:21.0 - 30:12.0	Tony	Uhm, no I am just thinking what the, what the... I mean there is just things like sharing space and computers and uhm confidentially all that kind of stuff is harder to manage when you are in a shared space and so, that's slightly on your mind and who might be around the corridors and uhm, the lack of privacy, uhm, yeah I don't know if that was the question?
30:11.9 - 30:17.1	Christian	Yeah, absolutely, it's about your experience of this. Anything in terms of the clients?
30:21.7 - 31:45.7	Tony	Well, I think they were very conscious of confidentiality actually 'cause being in a local service uhm, in a kind of local small town, uhm, there was certain clients certainly brought with them concerns about confidentiality, about was anyone in the community going to find out, uhm, their partner might be a well-known member of the community, uhm or they might be and they didn't want any material to leak out anywhere. Uhm, so I think they were also worried about what, what if they saw me or I saw them on the, the street.
31:45.7 - 32:10.1	Christian	So, sort of slightly changing topic, one of the things I was interested in is sort of the, the delineation between you as a person, between you as a therapist and between you as a primary care practitioner. Uhm, and I was wondering whether you can say something about that?
32:10.1 - 32:44.6	Tony	I am wondering whether I understood the question right, but I'll answer it as I heard it anyway. So, I suppose, me as a person, is this in reference to primary care, my relationship with
32:44.6 - 32:51.9	Christian	In reference to working existentially, existential-phenomenological in primary care.
32:51.9 - 32:54.8	Tony	How it delineates me as a person?

Time	Speaker	Content
32:54.9 - 33:38.2	Christian	I guess I'm wondering. I guess to be just transparent, where my question comes from is sort of the idea that, uhm I am wondering whether there is different roles or identities in the work that you do in primary care, as in I mean you are working there as you as a person, you working as a practitioner and you are working as an existential therapist there and there might be more identities and if you feel that there are other identities, let's talk about that as well, but I guess I was wondering what you make of that?
33:38.2 - 36:25.6	Tony	I suppose, uhm, [3s], as an iden...you know on the one hand I felt a part of the practice, so I felt that I had an identity within that, that service. But then as an existentialist I felt not wholly accepted by my sort of the GPs within the practice. Not personally, personally I felt perfectly accepted, but therapeutically, uhm my therapeutic orientation seemed to challenge, I experienced it as quite challenging for GPs. Uhm, because their, I realise that is a big generalisation, but there was a sense that, uhm, the clients, patients that they were referring uhm, they felt they had a much better insight of what needed to be done to them, uhm and they were referring to me to do it to them. On their behalf. Because they didn't have time to do it. And, because therapeutic approach is more questioning or less euthologising or would certainly challenge some of the assumption that the GPs were making about the clients, patients best interests then uhm, there was a tension there definitively, of who knows best and uhm, who has the more valid approach to delivering something as a service. Uhm, I say that, I don't think the tension was necessarily on my, I didn't feel sort of threatened by that, but I did feel that I needed to justify, I don't know, justify? I felt, maybe I didn't feel that I have to justify, maybe I felt that I wasn't fully accepted. In my own therapeutic approach. I think they felt there could be a more effective approach of treating clients.
36:25.6 - 36:27.3	Christian	How was that?
36:27.3 - 36:46.1	Tony	Well, it's difficult, it is challenging. Uhm, because I think we were working to different ideas, different uhm, outcomes I would suggest...
36:46.0 - 36:48.1	Christian	What are the different outcomes?

Time	Speaker	Content
36:48.0 - 38:23.4	Tony	The outcomes being that GPs you know, I think that there is a possible, I think the trend might be that you go to a GP to get something fixed. Or something, something cured, taken away from. My understanding is, uhm I suppose that we don't know what we are taking, what the consequence of taking something away might be. Or indeed why it might be there anyway, what other purposes it might serve. So, for instance someone suffering from anxiety as diagnoses by the GP would maybe feel that there is maybe some strategies and techniques uhm that can be put in place that can eliminate anxiety whereas from an existential perspective anxiety is seen as a part of the human experience. Uhm, and as much as it might be taking, it's also something, it's a sign pointing us to something else. It's not just something to be taken ...obviously uhm, it's there are ways of making it more manageable it which case it might be a different type of anxiety, more akin to everyday worry.
38:23.3 - 38:43.6	Christian	Yeah, yeah, so there was a, there was a, there were different perspectives uhm and I guess, again my question is maybe something along the lines of how did you work with those tensions? Or did you work with those tensions? Maybe you didn't.
38:43.6 - 39:54.5	Tony	Uhm, I think to be honest I avoided them with the GPs. [laughs]. Frankly because they weren't interested in hearing my views of the situation. [laughs] But they entertained me there, in terms of, they were not in any way rude or it just wasn't, just different perspective, uhm...But you know that is one of the things that comes from the primary care situation, when clients say, well the doctor said this would get rid of my anxiety. Or, but I think you get that in any setting. If anyone, you know even in private practice there is often an expectation or hope to get rid of something unpleasant. Which doesn't seem unreasonable. To hope for it. It might become less reasonable to expect it.
39:54.5 - 40:25.2	Christian	Yeah, yeah [smiles]. So I am getting the sense that you as a, you as a practitioner and you being a person is quite tightly interlinked?
40:25.2 - 41:45.0	Tony	Yeah, I think so. I mean I do think so. I suppose I recognise in myself my own desire for uncertainty and uhm anxiety to be kept to a very manageable level. But I am also quite aware that that's not what life is about. And so, it's there is something about living in the world with the various pressures the various expectations, constructs the, whatever you want to call them around and managing your own uhm, frustrations and of not having it as you like it. Necessarily. But then you never really know what you want [laughs]. You just got what you've got [laughs].

Time	Speaker	Content
41:45.0 - 42:40.2	Christian	Yeah, and I guess another point you were sort of touching on, which I am also quite interested in is you were almost kind of talking about representing your work uhm, you sort of talked about the sense of not being, uhm I can't remember the word you used uhm, sort of almost not being understood or not valued I guess in this, in this context. And we talked about, that's sort of towards the GPs and we also talked about sort of the client expectations, so I was wondering uhm, what it was like to represent existential-phenomenological practice to others, to other stakeholders, to others, to GPs to professionals, to clients...
42:40.2 - 43:50.3	Tony	Well it's uhm, it's difficult and it's in itself it's exactly what existential therapy is, because you, it requires you to, as an individual to kind of respond to or represent your own values in your own, stand by your own way of being, authenticity and uhm, and that isn't always to be in agreement with others. Uhm, it's feels like you are quite on your own at times. Uhm which can be challenging and difficult but that's also part of what you do. But at the same time for those who get it, or can hear it for whatever reason, it can be enormously liberating. For instance I had a client who, uhm, was in uhm, had very strong rigid religious views and assumed that those were hers and she had to live life by them. And by, although they were clearly causing her enormous distress and her actions were constantly undermining and defying what she believed her views, and so there was something about just allowing her to question herself and her own beliefs and her position, that she completely bought into. And although on the one hand it created more uncertainty for her, it actually quelled quite a lot of her anxiety. Uhm, because she was living in fear of what it meant to be constantly digressing from her religious views. But actually she was able to find a place that allowed her to retained both the sort of religious beliefs but also herself. To merger them I suppose. Bring them together.
45:29.8 - 45:48.3	Christian	So there is something in this sense of representing a way that is maybe not valued or maybe not understood as, as in terms of the, the existential practice.
45:48.3 - 46:08.0	Tony	Yeah, I think by just asking questions it challenges people's assumptions. And that, that in itself, done it a genuine way can open things up.
46:07.9 - 46:14.1	Christian	Did you ever question your existential-phenomenological way of working?

Time	Speaker	Content
46:14.1 - 47:36.4	Tony	Yeah, all the time. All the time. Particularly, uhm, I suppose when [3s] when it felt like I could recognise people making uhm, doing, being, living in a way that I felt was a hindrance to their own wellbeing. Whether it was, you know, medicating themselves with alcohol or recreational drugs, uhm or promiscuous sex or taking other forms of risk, uhm I found that quite hard. At that point I want to be much more directive and you know.. And I suppose I am sometimes in my questioning, in and in my exploration but I would say that the phenomenological side of my being with the client is impaired.
47:36.5 - 47:54.0	Christian	Yeah, and again sort of slightly changing the topic, although it might also be related, over the time that you were working in primary care did you feel that your perspective on your work changed?
47:54.0 - 49:16.9	Tony	Uhm, yeah. I think I listened in quite a different way. Again. very hard to bracket and uhm, kind of horizontalise the listening experience because there was an agenda, an agenda to 3[s] to move, shift, create a shift in clients. You know help a shift in clients, happening within a very short time period. Which uhm, requires quite a lot of you know active participants, active participation from the therapist, from me, to sort of maybe encourage guide, slightly push, nudge them in a direction would seem congruent and our relationship and from what information I had about them already.
49:16.9 - 49:21.4	Christian	So you would adopt that perspective more as you were working in primary care?
49:21.3 - 49:28.7	Tony	Yeah
49:28.7 - 49:30.8	Christian	So, there was a learning.
49:30.8 - 49:31.9	Tony	Yeah, that was definitively the learning that I got that I need to be more active in my participation.
49:31.8 - 49:33.2	Christian	Any other sort of learnings?

Time	Speaker	Content
49:33.1 - 50:04.8	Tony	Uhm, well rather than, I suppose yeah, one of my reservations beforehand was that you can't do, you can't do anything valuable with someone in such a limited space of time. But actually I think you can, I truly believe you can. I don't, I still don't think it's, I'd say its enough for some, but maybe it could be enough for some and have it more open-ended. I suppose what I mean by that is that some where happy to finish at six sessions, others, I wonder whether they stopped at four sessions, rather than taking the six because they felt that six wasn't enough and so they gave up. Whereas had they had in mind that they could have it ongoing, actually six might t have been enough for the.
50:43.0 - 50:43.8	Christian	Yeah.
50:43.8 - 50:52.1	Tony	I, I sort of noticed that, that was a part of it as well.
50:52.1 - 51:00.9	Christian	Yeah, ok. That was another shift in perspective. How did you, did you work with that?
51:00.9 - 51:35.6	Tony	Uhm I think just by being, more, more optimistic in my being with clients, that we, we don't know where we'll go until the end of the final session and that will only take us up to that point. But you know, until the last minute is up then there is always something possible there. So, I've I mean I had a sort of more optimism in my own way of being, I don't know whether that came across to clients or not [laughs] Or even if it would be helpful.
51:35.5 - 51:42.3	Christian	Would you go back to primary care? Have you considered working in primary care?
51:42.3 - 52:35.7	Tony	Yeah, I mean I would. Uhm, I would but only as a very small ratio of client work within a week. Uhm, because ultimately I don't find it as fulfilling as longer term working. Uhm, because I think it's a rich journey to go on and it seems a shame to constantly be ending with people. Uhm, yeah.
52:35.8 - 53:00.1	Christian	That's sort of the main bulk of my questions, uhm I was wondering whether there is anything that you wan to add to this? Overall, maybe the way you representing maybe the way you worked in primary care.
53:00.1 - 53:48.0	Tony	Uhm, the main thing is just the tension of managing people's expectations, managing clients expectations both through time and also because of where it, where it was positioned. And also of course uhm, because the, the clients who were referred to me didn't have a choice. So, they didn't know what they were getting. Uhm, necessarily, so I don't know, there is something about meeting their expectations

Time	Speaker	Content
53:48.1 - 54:04.9	Christian	And it terms of, we were talking about being valued and understood, in the way your work existential-phenomenological in primary care, is there anything to do this better?
54:04.9 - 55:03.2	Tony	Yeah, if someone could articulate what it is. In this time-limited fashion better than me, that would be helpful. To, uhm, to uhm, allow the sceptics to become less sceptical of the value, and I think it's entirely to do what can be evidenced and what can't be evidenced. And that of course just depends on what question you are asking and how you measure the answer. And I don't think that's necessarily a priority of existential therapy. Which I am ok with but for people who have to pay for services and things like that...
55:03.2 - 55:04.6	Christian	So, is there a particular form you are thinking about?
55:04.5 - 55:06.0	Tony	How do you mean?
55:06.0 - 55:08.3	Christian	Any way of how this could be done?
55:08.2 - 56:30.0	Tony	Uhm, I am happy you'll do it. [laughs]. No, I think it's been, it's been represented in various ways by you know, certainly by someone like Freddie Strasser who wrote Time-Limited ET, gives a convincing argument of why, of the benefits of how it can work and you know what the values are. But the point is that that doesn't address the measures that are already out there. So, you wouldn't be able to, if those were the , if the starting point is to answer the questions that exist out there on these and that's the measurement you need different questions to begin with. From us existentialists. Otherwise I have no real sense of how you would represent it anyway. Persuade others to that it's ...
56:29.9 - 56:33.0	Christian	Can you think of an outline of those questions? Or in what way they might need to change?
56:32.9 - 57:46.7	Tony	Uhm, it would be more about asking for descriptive answers from the clients I think. Because they are the ones that have the experience, they are the ones who know their experience. And they are the ones who can answer you know their experience; the question of what was their experience. And again, ok that might be less efficient system of gathering data. As opposed to something more directive, but that's not really a choice that's uhm, that's a very limited choice in how you respond to those questions. So, unfortunately again it's answering questions with questions as opposed to giving definitive statements or answers.
57:46.8 - 57:52.3	Christian	Ok, I guess before we finish, what was it like to talk about this, what it was like to reflect on your work in primary care?

Time	Speaker	Content
57:52.3 - 59:13.8	Tony	Uhm, it's good, it's good, but [3s] I don't think I articulated myself very well. That's all I can really say about that. But uhm, I don't feel I articulated myself very well, maybe I didn't think about it enough. But uhm, having gone through this process again it's, it's sort of how much more has come to light for me, of just being asked questions about my experience. Means that my perspective and my engagement with what was has shifted again and that's exactly, that's exactly a demonstration of why time-limited therapy can work because things aren't sedimented. Yeah.
59:13.8 - 59:40.3	Christian	Well, thank you very much.

IX. Sample Memo: Negotiating Practice in Primary Care

Memo Stage 1: After Analysing the Pilot Interview

Working in primary care appears to change existential-phenomenological practice in some ways, but at the same time, it also appears not fundamentally different to 'standard' existential-phenomenological practice.

Primary Care and bEPP are presented as standing in a fundamental tension to each other. Problem solving is contrasted with understanding. Therapeutic working from an EP perspective within primary care is also particular to that setup due to the requirements placed on the work. The setup of primary care was also mentioned as resulting in a change of work procedures. The setting of primary care necessitates some changes in the working procedure such as the incorporation of outcome measures and writing notes on sessions. These changes were perceived as outside imposition and were accommodated but not championed.

Extract that exemplifies this:

C: Ok, alright. Did you find those measures, ahm, did you incorporate them in your work?

A: Yes. I found a way to do it. Before I started there I absolutely detested forms...now I have just found like with everything else, if they are relevant to the client, they are relevant, if they are not, they are not. So, I'll ask what was like to fill in the form.

Questions:

- How does existential-phenomenological practice change as a result of being situated in primary care environment?
- What are the different aspects of this, is it only incorporating measures and writing notes or are there other aspects?
- Is time another aspect?
- What about the structure of therapy? Is it more structured?
- Is there a process through which existential-phenomenological practice changes into existential-phenomenological practice in primary care? Can that be conceptualised as learning?
- How can I even compare EPP in PC to standard EPP?
- Do practitioners make reference to this?
- Maybe incorporate question in interview schedule?

Memo Stage 2: Snapshot Mid-analysis

Throughout their work in primary care they come to realise that the tension between existential-phenomenological practice and primary care is not a forbidding, exclusive one, but rather they learn to work with the tensions.

As a consequence of the way in which practitioners experience and construe the primary care context in which they practice existential-phenomenological practice, a major aspect of the data represents the processes by which practitioners negotiate, work with and manage the tensions and clashes in values they experience. Invariably, all of the interviewed practitioners describe a process development that their practice undergoes. While individual practitioners both frame the tensions and their ways of negotiating them in different ways, there are some broad and representative themes across the data and more particular themes with reference to trainee practitioners, the way practitioners incorporate psychometric measures into their work, the way practitioners work with diagnosis and psychopathology, as well as how they negotiate goal setting and the limitations of time in their work.

Initially, many of the interviewed clinicians are sceptical whether they would be able to successfully practice in this context, particularly those practitioners of which their work in primary care forms a placement early on in their training which constitutes slightly less than a quarter of participants. However, less experienced trainees as well as more experienced trainees and qualified practitioners uniformly describe a number of processes of learning, adapting and developing ways to bridge some of the gaps between their own perspective and that espoused by the medical model that allow them to practice in this setting. While individual practitioners differentiate in the extent to which they describe a struggle there is an overall scepticism of the extent to which an existential-phenomenological way of working is possible in primary care.

Good quote:

Natalie: [...] like I said, at the beginning I felt very differently, I felt like oh my gosh I can't work to such short sessions, such short session model, that's not how I want to work, that's not free, that's not phenomenological (19:40 - 21:00)

Comments:

- I think is this a potentially important theme, as this goes to the heart of what might be going on while working existentially in primary care. There is meta category emerging here, that working in primary care is about learning to accommodate one's approach. Most practitioners report that they were initially sceptical of working in pc but most report that they have learnt that it is absolutely possible. I want to capture that with the questions/interview schedule. However, given that my interviews were mostly trainees I also want to attempt to specify more to what extent this learning to work in primary care has to do with learning that takes place as a trainee.

- Also, practitioners (including myself) do not know how to represent their work to the stakeholders (clients, professionals). I think I need more data on this one. Would practitioners find a 'clinical guideline' or something similar useful in order to represent their work better?
- This is linked to the previous category and I might even merge them at some point. I am wondering whether there is at times a gap between what clients expect to get from therapy and what practitioners deliver. I want to draw that out more, particularly in an action-oriented way: drawing out the strategies that practitioners employ.

Possible follow-up questions:

To what extent did your perspective on your work change over the time you were working in primary care?

- To what extent is this linked to being a trainee and learning 'the ropes'?
- In previous interviews there was a sense that representing bEPP (i.e. to clients, GPs, other professionals) is challenging? What is your perspective?
- How do you represent your work to others? What would help you to do that better?
- How do you negotiate the expectations of patients of bEPP?

Possible elements of finding a way to work in primary care:

- Importance of working 'like I wanted'
- learning to believe/trust in their work
- How much do I need to adopt?
- Adapting language & procedures, but acknowledging (with client?) that they are not 'Be-all & End-all'
- Acknowledging agenda
- Better than nothing - it's important what I do
- Reframing tensions as Givens
- PC is just another context,
- Buy into context/shift priorities
- Become more active

Short- vs. Long-term work

- Short- vs. Long-term

- Working directly
- Adaptation/Learning

Psychometrics:

- where it's relevant, it's relevant

Trainee experience

- Confidence
- trainee practitioners do not relate being in-training to changes in the way they work existential-phenomenologically, rather to a heightened sensibility to the tensions they experience.

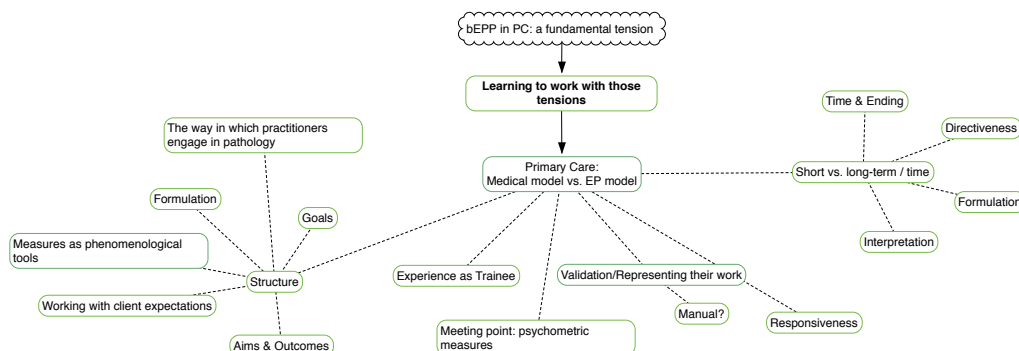
Pathology

- a way of relating and challenging

Goals and Changing Concerns

- Constructing an existential stance towards goals
- Clarifying Client Expectations

Both within the particular themes resulting from the analysis and also across the data as a whole a development of practitioners perspectives becomes visible from when they start working existential-phenomenologically in primary care to when they reflect back on their work retrospectively. I found a similar process reflected in the interview that I conducted with myself to illuminate some of my own assumptions prior to interviewing practitioners, however there are also some notable individual differences in the way in which practitioners reflect on their practice.



Memo Stage 3: From Memo to Major Category

Working with the rigidity of the 'medical' structure

Practitioners almost uniformly experienced the psychometric measures that were administered in all services such as the CORE system, the PHQ-9 or GAD-7 to provide both the individual therapy sessions but also the course of therapy in its entirety with a certain degree of structure. Practitioners are ambivalent in their response to this, yet, reference to such measures as fixed points were frequently practitioners initial response when reflecting on the structure of their work.

However, what seems interesting within practitioners accounts is the way they integrate these measures into bEPP, especially since a number of practitioners allude to being sceptical towards them, at least at first.

This relates to my personal ambivalence as a practitioner around the use of psychometric measures, especially as they often represent the interest of the service or researchers and which raises the an ethical question for me to what extent they for can and should the benefit of the therapeutic process.

Certainly, my own ambivalence is shared by about half the practitioners, however they also reported that this attitude has undergone a shift throughout their work in primary care that enabled them to work with their ambivalence rather than feel limited by it.

Yet, in the end the practitioners in this research are unanimously construct their attitude towards them as a phenomenologically useful for the therapeutic process.

Psychopathology

Across the practitioners' accounts and at times even within them there is an ambivalence towards diagnostic categories and the system of psychopathological classifications in use within the NHS and primary care. On one hand, practitioners describe diagnosis such as anxiety or depression as labels that impact on clients' experiences that might have the effect of reducing their sense of choice and freedom while on the other hand practitioners also describe the diagnosis that clients bring with them either from their GP, a previous psychotherapy or from an initial assessment frequently as the starting point for their work. Most practitioners mention that they take some time to understand the diagnosis of a client as a label with them and try and uncover what that means for them as a person. Particularly, one practitioner pointed out the usefulness of diagnostic labels as a starting point for exploration in the sense that it gives both client and practitioner a starting point within the vast and often confusing concerns that clients bring with them.

None of the practitioners reports making utilising psychopathological classifications based on a diagnostic manual for their own practice and throughout the data there appears to be an unarticulated consensus that this would not form part of an bEP approach to therapy

The position that practitioners take in their existential-phenomenological stance towards pathology also frequently finds its way into the client work. Practitioners often describe how client's expectations when they come to psychotherapy emerges as an issue that becomes part of the therapy especially when diagnostic labels evoke specific expectations

Practitioners see it as an important aspect of their work to inquire into the assumptions that might lie behind the diagnostic labels clients arrive with.

In this sense practitioners uniformly see it as their task to de-pathologise

Time

Overall, the time-limit presented by the primary care setup is experienced as challenging at least initially when practitioners begin to work in this way and a significant departure from open-ended work. Practitioners report uniformly that they needed to 'get their head around' this way of working from an initially sceptical perspective as to whether and how an existential-phenomenological perspective would fit within a 6-10 session brief framework. Only one practitioner did not make reference to this challenge, however he also constructed his existential-phenomenological therapeutic work to draw on a wide range of previous experience in other modalities and settings.

Generally, brief work forms a departure from a traditional phenomenological stance for most practitioners and requires them to change their perspective.

This especially holds for trainees, who experience open-ended work as more safe and providing them with the opportunity to develop their therapeutic work more slowly following their clients narrative as it unfolds. Brief work on the other hand, is experienced as faster paced and requires more confidence on behalf of the practitioner as practitioners more frequently find themselves constructing an early hypothesis or formulation of the clients' concerns which they share with the client in order to establish a basis or direction for the work. This is a departure from what practitioners construct as a traditional phenomenological stance (see a detailed discussion theme on short vs. longer-term work)

Some of the frustration that practitioners experience similarly to Robert, is present in having only a very limited number of sessions for clients to experience some change in their condition. In about half of the accounts, practitioners refer to a sense of pressure to achieve certain outcomes either in terms of service-set goals, i.e. improvement in psychopathological scores, in terms of the goals clients set themselves for therapy or in terms of goals that therapists set for their clients. Although as Lindsay points out in the following extract, 'giving in' to pressure to achieve a particular outcome is constructed as un-existential, particularly when these outcomes are not set by the client themselves.

Directiveness

Yet such a shift in perspective is bound up with the tension in short-term work between the urgency of both therapist and client to respond within the limited time-frame and the focus on the meaning that the client attributes to their accounts. For practitioners this

tension manifests in the choice points that they are presented with when they respond to their clients concerns: to what extent they can follow their clients in their exploration and to what extent they need to direct the process so that it becomes therapeutically helpful for the client given the limited time available.

In this sense, short-term therapy is constructed to put more emphasis on the practitioner to make decisions and to shift from what some practitioners have called the traditional phenomenological stance towards a more directive and interpretative stance.

At times this involves making the choice points transparent to clients and coming to a joint decision and other times this meant to interpret the clients' needs.

Validation

Another theme that emerges from practitioners' accounts of bEPP as a therapeutic model is the sense that practitioners struggle with representing their work to outsiders, including clients, other health professionals and the wider therapeutic community. Throughout the entire data set, there is a unanimous agreement in the narrative that practitioners feel little understood in their existential-phenomenological way of working by other health professionals and therapists from different perspectives, especially CBT but also by clients. This includes the appreciation that bEPP and the medical model of primary care at times clash in terms of their outlook on change and that some of the misunderstandings indeed stem from clashing perspectives: while primary care is constructed as oriented towards problem-solving, bEPP emphasises understanding and sense making that does not problematise this process. However, practitioners construct this clash as being unarticulated.

In addition to the sense of not being understood some practitioners also framed articulating their stance towards pathology and the medical model, the process of change and the therapeutic outcomes of bEPP in primary care as challenging. Some practitioners find it difficult to express the existential-phenomenological perspective on therapeutic change, i.e. psychological vs. behavioural change, on the outcomes of therapy and on how to measure or present those outcomes.

Conversely, other therapeutic models, again mainly CBT are being seen as being clearer in their representation of themselves as far as outcomes and the therapeutic process are concerned, especially in terms of more concrete and measurable therapeutic outcomes.

One way of gaining validation is seen in the construction of a more clearly articulated model either for others, i.e. In the form of information material or workshop for other professionals and clients or for existential-phenomenological practitioners themselves. Despite their ambivalence towards such a model or set of principles as laid out earlier, a more concrete articulation of bEPP in primary care is generally welcomed as a way to champion and validate the work practitioners undertake, especially that of trainees who struggle to develop their own stance towards primary care and the medical model while at the same time having to find their way working within a existential-phenomenological perspective.

Working with client expectations

Another theme might be working with the expectations and preconceptions that clients bring to existential-phenomenological practice which often stand in tension to how practitioners see the remit of their own practice. Such expectations might include ideas about the structure, time-frame, outcomes and nature of the therapy: clients might expect that existential-phenomenological practice provides them with a clear structure, advise and outcomes which is often described as rigid and which is challenged by practitioners who use more exploratory language such as journey, explore, engage with and be playful or curious about when describing what their way of working offers.

Often client expectations are seen as framed by the context of primary care or by previous experience of other therapeutic approaches

Practitioners value the negotiation of these tensions as a fundamental part of the therapy as they are seen to be contributing to setting out the frame for the work, define the remit of therapy and establish the relationship between therapist and client.

However, practitioners acknowledge that these negotiations have the potential to be anxiety-provoking for the clients as they challenge their preconceptions and also potentially for the therapist as they need to defend their way of working within a context that favours more medical perspective.

In this way, both client and therapist are expected to remain open and curious as to the outcome and process of therapy